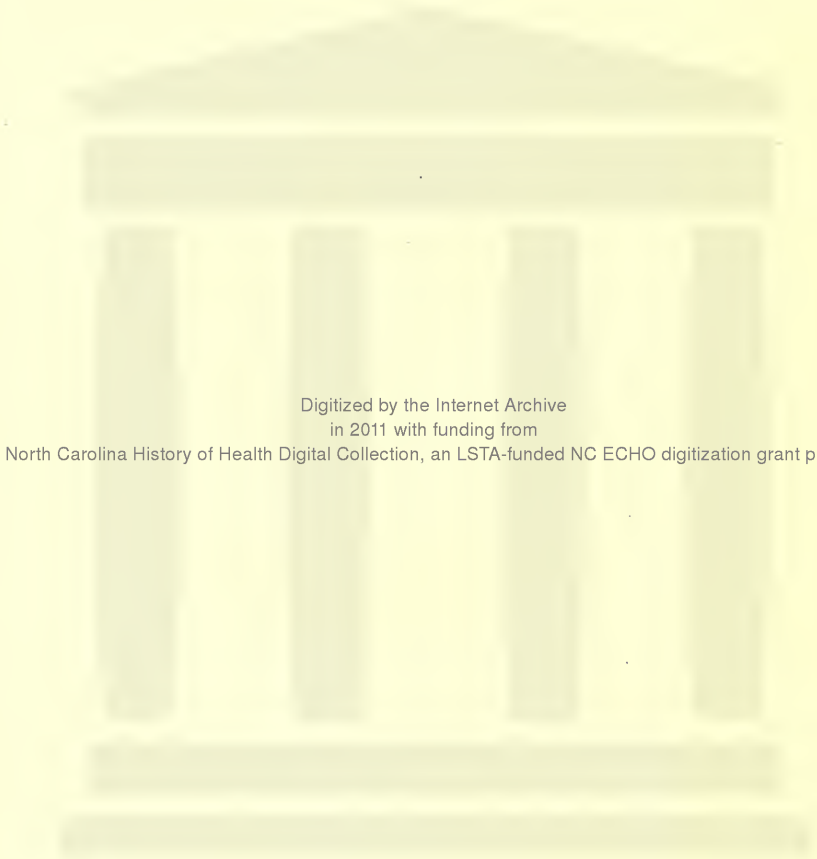


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VOLUME 75 NUMBER 1 JAN./FEB.

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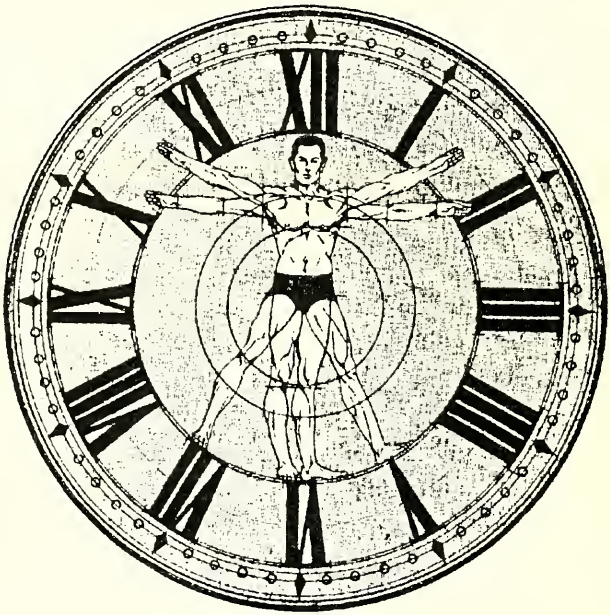


Meet Mary Lynn Bell—pharmacist, entrepreneur, and founder and CEO of one of the country's most unusual pharmacy practices. *Story on page 5.*

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(USPS 091-280)

Jan./Feb. 1995 **Volume 75** **Number 1**

ISSN 0528-1725

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The Carolina Journal of Pharmacy is published monthly by the North Carolina Pharmaceutical Association, P.O. Box 151, Chapel Hill, NC 27514. *The Journal* is provided to NCPhA members through allocation of annual dues. Subscription rate to non-pharmacists is $25.00 (continental U.S.). Overseas rates on request. Second class postage paid at Chapel Hill, NC.

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PRESIDENT'S MESSAGE

1995 NCPhA NEW YEAR'S RESOLUTION—WHERE HAVE WE COME FROM, WHERE ARE WE GOING?

January is a time when all of us reflect on our past accomplishments and experiences, assess them, then project our future directions. I shall take this opportunity to share with you my thoughts concerning the direction and future of our Association. Meetings and discussions among the leaders of NC Society of Hospital Pharmacists, NC Retail Pharmacy Association, the NC Chapter of the American Society of Consultant Pharmacists, chain pharmacy leaders, and the two schools of pharmacy are ongoing. Joint ventures of committees, continuing education, and legislative agendas have been implemented. Your elected leaders are talking, meeting, and working together. Chain pharmacy and retail pharmacy have met for the first time to plan strategy for legislative action. I see us progressing toward "One Pharmacy Association" representing all pharmacy groups in North Carolina. We can begin the journey by expanding the Leadership Forum and possibly holding a joint convention that will bring us all together under one roof. We can complete our journey by realizing once and for all that we are a single profession with much more in common than our diverse opinions indicate.

Legislative and regulatory action is upon us as the 1995 NC Legislature convenes. We are proud of our accomplishments with Freedom of Access and Mail Order Regulation laws on the books. Yet new and even more critical concerns lie ahead. We are focusing on the NC Medicaid proposal in Mecklenburg County, anti-discriminatory pricing legislation,and NC health care reform. The Pharmacy Day in the Legislature is scheduled for February 15th. I see our future as requiring the joint funding and grassroots lobbying of all pharmacy groups. What great things we could accomplish with a Pharmacy Super Fund directed by a powerful team of lobbyists!



Joseph A. Edwards Jr.
President NCPhA

We now have representatives from all areas of pharmacy at the table to address the Pharmacy Practice Act. Great discussions have occurred, but the proof of our labors will only be realized when legislation and regulation proposals are submitted that will greatly expand the role of pharmacists in our health care system.

There is a puzzling question that I ponder almost daily. As pharmacy gets more and more complex and the individual pharmacist has less impact on his profession, why is membership in the NCPhA decreasing? We have just completed a comprehensive survey of members and nonmembers. We now know what you want, and we are committed to bringing about the changes needed to

improve our Association and make it attractive to all pharmacists in North Carolina. Our Membership Committee has as its theme "Pharmacy 3000," and is committed to bringing our membership to 3,000 members. We need for all of our members to spread the word.

Pharmaceutical Care was only professional rhetoric several years ago. Now, through the efforts of the Pharmaceutical Care and Compensation Committee, it has become the banner for pharmacy practice. This year will see the advent of the Pharmaceutical Care Showcase in April and a test market for demonstrating the value of Pharmaceutical Care in the ambulatory pharmacy setting.

Through the efforts of our Finance Committee we have finally been able to put together an accounting system for monitoring and forecasting our Association's fiscal integrity. We will now be able to track our progress and budget our resources for best meeting the needs of our membership.

Continuing education has been and will continue to be a primary focus of our Association. The Continuing Education Committee now has more authority to produce a higher quality product. Convention planning is now the responsibility of this committee. Joint ventures with other pharmacy groups will make a good product even better.

We have now developed a three-year Strategic Plan for our Association. I hope all of our members will read and endorse the Strategic Plan on page 18 in this Journal. I also hope the Executive Committee will commit to following the plan to completion.

Finally, 1995 should usher in a major shift for pharmacy in North Carolina. More changes in health care have occurred in 1994 than in any previous year. There has been much turmoil and controversy in all areas of health care—legislatively, sociologically, and professionally. Pharmacy is no exception. There is a new leadership in pharmacy that is not satisfied with the status quo, with old values and expectations, with restrictive pharmacy laws, with the lackadaisical attitudes of some pharmacy leaders, and with general apathy in our profession. There is a mandate out there in 1995 that change is good. We are getting up and demanding more—new ideas, new responsibilities, new respect, new power, and financial and professional growth. You can help. Get involved and get other pharmacists who are not members to join our great Association.

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AN INTERVIEW WITH MARY LYNN McCRANIE BELL

by Wanda B. Norris, Pharm.D. Candidate
Campbell University School of Pharmacy

Mary Lynn McCranie Bell is a pharmacist, entrepreneur, and founder and CEO of one of the country's most unusual pharmacy practices. Her *Ask The Pharmacist* is a much publicized telephone service that provides callers all over the United States 24 hour access to counseling by a professional pharmacist. The innovative style of this practice and the business savvy its establishment depicts contradicts the modest self description of its founder when she declares: "There's nothing special about me!"

Mary Lynn graduated from the University of North Carolina at Chapel Hill in 1967 with a B.S. in Pharmacy. It was a time when the profession was dominated by males, and some people had no faith in a woman pharmacist. "I remember one man who was not even willing for me to fill his prescriptions," Mary Lynn recounts. In commenting on the entrepreneurial spirit that led her to persevere in the profession and to succeed in business, Mary Lynn refers to her personal role models: "If there is anything in my background that has motivated me to do this it is the examples set by the women in my family. One of my grandmothers was the first postmistress in the state of Georgia, and the other owned the general store in Milan, Georgia. My mother's two sisters were teachers, and, while my father was in school, my mother began her own business."

Mary Lynn was born in Milan, Georgia, but moved to Newton, N.C. at a young age. It was in Newton that she was inspired to become a pharmacist. She describes warmly the pharmacy she remembers from her hometown: "Ernie Clapp was a community pharmacist in Newton. He was also city mayor. He helped people who went to school and did not have the means to do so. Most people were not aware of all the good he did. He also owned the pharmacy where everyone hung out when I was in school. I wanted that! I wanted to be a community pharmacist, to own my own store. And I wanted it to be a place where people could gather and where they could be taken care of by a pharmacist. I had a big dream as far as pharmacy was concerned!"



Mary Lynn McCranie Bell

The decision to attend UNC was made early in Mary Lynn's life: "I decided in 1957 as I followed the Carolina basketball team that I wanted to come to school in Chapel Hill. I was in the sixth grade and I never changed my mind." When Mary Lynn was finishing high school and applied to Carolina, it caused a bit of a stir in her hometown of Newton. "There weren't many women admitted here then, and my mother's friends just couldn't believe she would let me come to school here." Her mother had great faith in the morals instilled at home over the 18 years of her daughter's life, so the dream of the sixth grade basketball fan came true. Mary Lynn's enthusiasm for sports at North Carolina has not diminished. "I'm an obnoxious Carolina fan and I know it! Any time I watch basketball or any college sports I make sure that I'm with people who love me and understand that." She still prefers the

Raleigh, Durham, Chapel Hill area to any place she has ever been. "I've traveled a lot in the course of establishing this business, but," she says, "I love it when I get back here! Everything just looks different as you get near Raleigh. I am exactly where I want to be!"

After receiving her B.S. in pharmacy at UNC, Mary Lynn went to Winston-Salem, N.C., where she practiced in community pharmacy and reared two children. Commenting now on her accomplishments, she says that her daughter Lynn and her son Keith are " both nice people, and that," she says, "is my greatest accomplishment. I know it sounds hokey, but I like my children very much. In fact, the older they get the better I like them."

In 1978 Mary Lynn became Assistant Director of Pharmacy Practices at North Carolina Baptist Hospital in Winston-Salem. During her three years there she established and operated the hospital's first outpatient pharmacy. She also coordinated pharmacy information and provided continuing education classes for pharmacy technicians.

In 1986 *PharmaStat* was founded by Mary Lynn and her friend Laura Burnham. The business provided relief pharmacists for places that needed them. "At the time we started that company there were many areas that were pharmacist poor and other areas had pockets of pharmacists," she explains. "We planned to take the supply and meet the demand. It was a plan that provided for pharmacists to be compensated for travel time. The employers thought this was more than fair. They were willing to take that responsibility." Mary Lynn is no longer involved with *PharmaStat*, but, she says, it is still doing well.

In 1988 she was elected to the Board of Alumni of the UNC School of Pharmacy, and in 1989-90 she served as Secretary-Treasurer of that board. Also in 1989 the North Carolina Pharmaceutical Association selected Mary Lynn as one of the Outstanding Women in Pharmacy in North Carolina.By 1990 Mary Lynn was back in Chapel Hill contemplating a new business venture. "That summer I was recuperating from surgery. During that time I decided I would like to start another company. Feeling that the public couldn't get to the pharmacist any more, (like they could in Ernie Clapp's pharmacy years ago in Newton), I had the idea of a 900 number for an individualized consultation without anyone standing around. People could call at their leisure and get confidential counseling in the privacy of their own homes. Sometime that same summer, *USA Today* ran a one-day APhA hot line. There were so many calls they couldn't handle them all! The questions scared me. One woman who called was taking an antidepressant and did not know why. She said she knew she had an allergy and she wanted to know if that was why she was taking the medication." This was obviously a person who had not received to obtain good pharmaceutical counseling. It emphasized a weakness in the communication between patients and health care professionals. This cemented Mary Lynn's idea concerning a place for *Ask The Pharmacist* in pharmacy practice.

Mary Lynn discussed her plan for *Ask The Pharmacist* with a business consultant and he liked the idea of a 900 number information line. She received help and encouragement from the UNC School of Business and was encouraged to go further to set up the company. Marketing specialists, attorneys, and accountants were recruited and the base was built. *Ask The Pharmacist* was launched as a 900 telephone service in 1991. "When the 900 number service was presented in *Forbes, Fortune, The New Yorker,* and *The Wall Street Journal* we were fortunate that corporate America saw it. They were thinking, at the same time, that the idea of an 800 number was good. We had already begun to develop the 800 number concept so that major corporations could use us as information providers."

"Between February 11, 1991, (when we went live nationally), and now, (a little over three and one-half years later), we have

really been fortunate. Our strong client base has continued to grow. We've added two new clients this month. We are very lucky with projects that we have from Eli Lilly and we are even adding more. We have done everything from launch two major products nationally to act as part of medical services for one company 24 hours a day. We do customer services for another company, and work for a major credit card carrier to provide a service for their older members. There is a national chain with over 1000 stores for whom we do 24 hour counseling, so their pharmacists always have additional consultant capacity."

Mary Lynn stresses the importance of the pharmacist as the core of her business. "The pharmacists are the number one priority in the business because the pharmacists are the backbone, the pivotal point, of the company."

Mary Lynn stresses the importance of the pharmacist as the core of her business. "The pharmacists are the number one priority in the business because the pharmacists are the backbone, the pivotal point, of the company." She cites extensive training of her employees: "We're doing things that haven't been done before. We have a strong intellectual capacity here. These are good pharmacists and good communicators. As new training is developed it will be with the input of the pharmacists. This is important because there is no prototype for what we are doing. This is innovative pharmacy." She says the focus of *Ask The Pharmacist* is the quality which delineates it from all those who claim to serve the same purpose. "There are others who claim to do what we do. Some of these are telemarketers. We are very focused as far as pharmacy is concerned. Our pharmacists do not consider this to be telemarketing. They consider this to be a form of pharmacy practice. This places us in our own niche. The specialty of the company is not telemarketing. If we lose the focus of the company I no longer will consider this to be a non-traditional practice."

Mary Lynn attributes a great deal of the success of her company to her consultants. "Those who have advised me must be given a tremendous amount of credit for where the company is at this point. Our mission statement quotes Vince Lombardi to the effect that if you strive for perfection you will attain excellence. In this business we do that. Milton Whaley, a member of our Board of Directors, said it well: 'Underpromise and overproduce.' Giving our clients more than they ask for is what keeps us growing!"

Concerning her own transition into the business world, Mary Lynn says, "It's been an interesting growth because all my experience has been hands on experience. We've been fortunate. I've made some right turns. At the same time, I've gone through some terrible learning curves because I had absolutely no background in business. I believe one thing that has worked in my favor is that when I made mistakes, in good faith I went back and changed them."

Mary Lynn McCranie Bell had a big dream for a career in pharmacy and she has surpassed her original expectations. "Obviously I've done more than I thought I would at first," she says. "I haven't practiced myself for a while and I've gone into business, but pharmacy was the springboard for me. I am so very grateful to have this degree in pharmacy!" She is a successful businesswoman, President and CEO of a nationally known company, but first, Mary Lynn declares, she is a pharmacist. That is something of which she is very proud!

Wanda Norris is a Pharm.D. candidate at Campbell University School of Pharmacy.



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NCPhA ELECTIONS

Ballots for the NCPhA's 1995 elections will soon be mailed to all Association members. The slate consists of two candidates for president-elect and six candidates for three member-at-large positions on the NCPhA Executive Committee.

For the three member-at-large positions, the three candidates who receive a plurality of votes will be elected to a two-year term.

NCPhA members will receive their official ballot in mid-February. Ballots are to be returned within 30 days of receipt. Ballots will be counted by the Elections Committee in early March and results published in an upcoming issue of *The Journal.*

Successful candidates will be installed in their new offices in May 1995 during the 115th NCPhA Annual Convention in Asheville, North Carolina.

The 1994 NCPhA Nominating Committee presents the following slate of officers which was accepted by the membership at the 114th Annual Convention in May 1994.

Biographical data is present for each candidate. Candidates for positions on the NCPhA Executive Committee were asked to submit a response limited to 150 words or less on: **"How can NCPhA best meet the needs of the membership as health care reform evolves?"**

Members of the 1994 Nominating Committee were Chairman, Joey Edwards, Kevin Almond, Cindy Bishop, Gary Glisson, David Moody, and Lori Setzer.

FOR PRESIDENT-ELECT

one to be elected



Rebecca Wheeler Chater
Fayetteville

Rebecca Chater is a community practitioner and store manager with Kerr Drug in Fayetteville. She is a 1985 graduate of the UNC School of Pharmacy and has been a member of NCPhA for ten years. Rebecca has been on the Executive Committee of NCPhA for three years. She is a past chairman of the Pharmacy Week Committee and has served also on the following committees: Employer/Employee Relations, Public and Professional Relations, and Membership. She is a member of PharmPAC.

Rebecca is a past president of the Wake County Pharmaceutical Association and Wake County Pharmacist of the Year. She is past recipient of the Marion Merrell Dow Distinguished Young Pharmacist and the Syntex Practitioner-Instructor of the Year awards. She is a 1992 graduate of the APhA-SmithKline Beecham Program in Community Pharmacy Management. She is an active member of APhA and NARD, and has

served as a delegate to the APhA Annual Conventions.

Rebecca currently serves on advisory boards for Glaxo, SmithKline Beecham, UNC P-I Development, Campbell P-3 Development, UNC Pharmacy Alumni Association, NC Medicare, and APhA-SmithKline Beecham Community Pharmacy Management Program. She is a reviewer for *American Pharmacy*, and a member of the SmithKline Beecham Speakers' Bureau. Rebecca is involved in civic activities in the Fayetteville area, and is a member of the Cape Fear Pharmaceutical Society.

"How can NCPhA best meet the needs of the membership as health care reform evolves?"

We must make health care reform happen for us, rather than letting it happen to us. An ambitious charge? Absolutely, but one fully within our capability as an Association. NCPhA must serve as a uniting force among the pharmacists within our state. We must collectively show a level of commitment to pharmacy never before seen in our profession. The time is NOW!

There is no longer room for naysayers or those who fail to get involved, or drag their heels in doing so. Each and every one of us must get involved. Prosperity for our profession in the 21st century, plainly and simply, means work. Hard work.

As NCPhA leaders, we have a responsibility to you to dig for the facts regarding reform and communicate them to you effectively. It is critical that information be disseminated clearly and in a timely fashion. As your Board, we must listen to what you have to say. We must make wise, careful decisions and initiate concise, proper action.

It is imperative that we be politically strong. We must be aggressive in interfacing with legislators. If we want them to understand pharmacy issues, we must communicate with them. Finally, we must be dogmatic in accomplishing our goals. Our plans for the future must be developed strategically, and followed through to completion. Ambitious? Yes, and absolutely necessary.

It is certainly a privilege to be nominated for this office. I would be honored to serve you.



Phillip F. Crouch
Asheville

Phillip Crouch is the pharmacist/owner of Ideal Drug Store in Asheville.

He is a 1961 graduate of the UNC School of Pharmacy and a member of Kappa Psi.

Phillip has been a member of the NCPhA for 28 years. Currently he is chairman of the Resolutions Committee and past member of the Executive Committee. He is a member of the Board of Pharmacy Network National Corporation, North Carolina Retail Pharmacists Association, and NARD. He is past president of the Buncombe County Pharmaceutical Association and a member of the Western N.C. Pharmaceutical Association.

He is an active member of St. Paul's United Methodist Church. For a number of years he was involved with the Western North Carolina Methodist Building Teams, serving on the committee, as well as acting as team leader. He now serves as vice chairman of the Asheville Housing Authority Board, on the board of the Asheville Merchants Association and as a member of the West Asheville Business Association.

"How can NCPhA best meet the needs of the membership as health care reform evolves?"

Meeting the needs of the membership of the NCPhA can only be accomplished by meeting the professional goals of all pharmacists in the state, including retail, chain, hospital, consulting, industry, research and educators. The NCPhA must be able to com-

nunicate as one voice for all pharmacists in Health Care Reform. None of us knows what will evolve but change is coming whether we like it or not.

One way we might unite is by the formation of Academies to the NCPhA. For example, hospital pharmacists, through an Academy, may have its president or an appointee become a member of the NCPhA Executive Committee where each one may voice his views while still maintaining his own identity. Only by understanding each groups' needs and problems can we solve them cooperatively. By doing this, would not our political clout increase?

We as pharmacists must work collectively, and emphasize the theme: UNITED WE STAND; DIVIDED WE FALL. Become aggressive, face issues head-on so we as the united can resolve the formidable problems we encounter in pharmacy. We must gain control of our profession; not allow drug manufacturers, insurance companies and bureaucrats to dictate our destiny. As members of the most trusted profession in the country, we need to speak with one assured voice as an internal part of HEALTH CARE REFORM and to be adequately rewarded for this responsibility.

☑ For Member-at-Large

three to be elected to a two-year term



Randy G. Ball
Wake Forest

Randy Ball is a 1981 graduate of the UNC School of Pharmacy and is a practicing pharmacist in Wake Forest. He has a diverse professional background having worked as a community pharmacist, a consultant for substance abuse hospitals, and as a consultant for geriatric pharmaceutical care in long term care facilities.

Randy is an active member of NCPhA. He is currently chairman of Membership Development and is past chairman of the Third Party Committee. In 1990, Randy was recipient of the Marion Merrell Dow Distinguished Young Pharmacist of the Year award. Randy is also a member of the Wake County Pharmacy Association and has served on its Executive Committee.

"How can NCPhA best meet the needs of the membership as health care reform evolves?"

Although health care reform has not been the revolution that was initially expected, the fact is that reform has occurred and brought about major changes in health care. It is important that NCPhA meet the needs of its membership by becoming the spokesman for Pharmacists as a primary care giver in the new health care environment. Change can mean new opportunity, but only if NCPhA is proactive in the legislative arena. NCPhA must closely monitor any legislative action both on a national and state level to position the Pharmacist as a integral manager of patient care. As health care reform continues to evolve, NCPhA must be the diligent watchman to safeguard our position in the new health care system.

NCPhA can best meet pharmacists' needs by using its resources to unite all disciplines of pharmacy. By doing so NCPhA can become the organization that will represent all pharmacists in this reform environment. This will give NCPhA the strength to enact positive change that will favor pharmacy, rather than reacting to changes forced on pharmacy by others.



Ross W. Brickley
Clayton

Ross Brickley is a pharmacist for Neil Medical Group–Pharmacy Services Division in Kinston. Prior to his current employment, Ross owned an independent retail pharmacy and a long term care provider pharmacy. He has served on the Legislative Affairs, Professional Affairs and Constitutional and By-Laws Committees of NCPhA. Ross is a member of the American Society of Consultant Pharmacists (ASCP) and has served on the Public and Professional Affairs councils for ASCP.

Currently, Ross is Director of the North Carolina Chapter of American Society of Consultant Pharmacists (NCASCP) and has served on the Legislative Affairs Committee of NCASCP. He is a past-president of the Chamber of Commerce, Lions Club and Public Library System in Hesston, Kansas.

"How can NCPhA best meet the needs of the membership as health care reform evolves?"

As the educational role of pharmacy increases, it is more important than ever for us to document outcomes and relate this information to our legislators, regulatory officials, other health professionals, and the general public. I feel that NCPhA can represent us in "educating" legislators and the public about the impact pharmacists have in improving patient outcomes and reducing costs.

It no longer is enough that we know about the good work we are doing. With health care reform efforts ongoing at the state level, we have to tell our story locally and statewide more than ever before. A championship team in a sport wins because of a group effort. It is imperative that pharmacists approach state government and managed care organizations with clear, consistent messages. Why not let NCPhA be the vehicle to deliver those messages!



J. Frank Burton
Greensboro

Frank Burton is the owner of Burton's Valu-Rite Pharmacy in Greensboro. He received his BS in Pharmacy from the University of North Carolina at Chapel Hill. He is a past president of the NC Pharmaceutical Association and is past chairman of the NCPhA State Legislation Committee. He also chaired the NC Pharmacy Committee on Patient Counseling standards.

Frank has been an active member and officer of many other organizations and associations, including the Guilford County Society of Pharmacists, NC Pharmacy Political Action Committee, NC Pharmacy in the 21st Century Commission, and the American Cancer Society. He is currently on the Board of Directors of the UNC School of Pharmacy Alumni Association and the Pharmacy Network National Corporation. Frank also has a weekly pharmacy call-in radio show on a Greensboro radio station. In 1991, he was selected by Physicians' Health Plan of NC as their community pharmacist-of-the-year.

"How can NCPhA best meet the needs of the membership as health care reform evolves?"

Although the Clinton Healthcare Plan, as

well as the Republican Alternatives, were stalled in the last Congress, it is a sure thing that some form of health care reform will come up again this year. The NC General Assembly will also be considering many health care initiatives that will impact pharmacy. The NCPhA must play a major role in these legislative activities, especially in Raleigh, if it is to best serve its members during the health care reform process.

The leaders of the NCPhA must first and foremost listen to the membership. They must then formulate that input into achievable legislative goals. Once these goals are defined, NCPhA must organize an all-out lobbying effort from members throughout the state, because a handful of officers and committee chairmen going over to Raleigh will not get it done!

In addition to taking a proactive role in the legislative process, NCPhA must continue to provide its members with the latest news and information on all fronts of the health care reform process. This is imperative if members are to be asked to make informed decisions on issues that the Executive Committee must act upon quickly.

Most importantly, NCPhA must increase its membership so that it represents a significantly larger percentage of the pharmacists in North Carolina than it does now. To maximize our political influence, NCPhA needs to be recognized as speaking for the majority of pharmacists in the state. While NCPhA must be sensitive to the concerns of members from many different practice areas with sometimes quite different priorities, now is the time for all of us to put aside our differences and work together to secure an important role for pharmacy in any programs brought about by health care reform.

Retain this information about your NCPhA candidates so that you may refer to it when your ballot arrives in the mail.



Gary R. Glisson
Nashvillle

Gary Glisson is a 1978 graduate of the University of North Carolina School of Pharmacy. He has been the owner and president of Ward Drug Company in Nashville, NC since 1986. A member of NCPhA for 15 years, he has served on several committees including the Retail Community Pharmacy Committee. He is a member of the North Carolina Retail Pharmacists Association. As one of ten pharmacists chosen nationwide, Glisson served as an at-large delegate to the Pharmacy in the 21st Century symposium in October 1994. As a member of NARD, he has presented colleagues-in-consultation seminars at two annual conventions.

A former Jaycee and Lion, Glisson currently serves as president of the Nashville Chamber of Commerce. He also is a member of the Nash County Economic Development Commission. Gary is a member of Nashville United Methodist Church, and he serves on two of the church's committees.

"How can NCPhA best meet the needs of the membership as health care reform evolves?"

The NCPhA must become a proactive force for its member pharmacists in North Carolina by acting, not reacting, to changes in our health care system. Pharmacists must prepare themselves to become gatekeepers of the health care system by moving from a strictly dispensing role into a pharmaceutical care role and our Association must assist in this transition. In addition, the NCPhA must assist its members by taking a lead role in dialogues with payers of health care

dollars to assure us of payment for pharmaceutical care.

We must all become more active on a grassroots level so our legislators will understand the value of pharmaceutical care. This means personal contact in addition to letters and donations. The activity of the NCPhA membership is linked directly to the future of our profession.



Josiah R. Whitehead
Raleigh

Josiah (Joe) Whitehead received his BS degree from Butler University School of Pharmacy in Indiana and his MBA from Xavier University in Ohio. Joe currently serves as special assistant to the Dean at Campbell University School of Pharmacy. Joe retired as vice president of corporate affairs from Burroughs Wellcome after 36 years. While at Burroughs Wellcome he held many positions in management and administration.

Joe has been a member of NCPhA for over 10 years. He currently serves as chairman of the Professional and Public Relations Committee and is a member of the Membership Development Committee. Over the years, he has chaired and served on numerous NCPhA committees. For his contributions to the profession, Joe has been recognized with the Don Blanton Award and the UNC Distinguished Service Award. On the national level Joe is a member of NARD, APhA, and is a full fellow of the American College of Apothecaries. Joe was appointed by Governor Jim Martin to the Board of the North Carolina Foundation for Alternative Health Programs.

In his community, Joe serves as president of the Poe Center for Health Education; vice-chair of NC Public Television Foundation, executive committee of Wake Medical Center Foundation; member Rex Hospital Foundation; Member Board of Trustees Children's Museum About the World; member of White Memorial Presbyterian Church, Raleigh; and member of the State Advisory Board of the American Cancer Society.

"How can NCPhA best meet the needs of the membership as health care reform evolves?"

1. To provide timely and accurate information. If the coming year is anything like the one just passed, we will all be inundated by a blitz of information from numerous sources. Given the election results last November, the debate will be reshaped and the issues redefined in the coming months. This means much of the old information is not appropriate, and there is sure to be much new information to be digested. A good deal of the action may shift from the national to the state level. NCPhA can serve as a clearing house to keep our members informed about what is being proposed, what action is being taken or likely to be taken, and what the thought leaders in health care are saying. This should enable our members to better crystallize and articulate their thoughts on the issues.

2. To lead our members to have realistic expectations regarding the outcomes of the debate and the implications for pharmacy practice. The temptation to which some professional associations in health care have succumbed, is to overstate both the role played by the association in shaping the debate and the expected results. NCPhA must not fall into this trap at the state or national level. Our efforts must not be diminished in working for the best interests of Pharmacy, however we must be realistic in what we promise.

3. To provide constructive opportunities for involvement by our members. The range of activities include letter writing to elected leaders, contributions to our Political Action

Committee, legislative visits, serving on advisory boards and commissions, and good old fashioned grass roots politicking. NCPhA can regularly call to the attention of our members the need for and opportunity to take these actions. An informed and motivated membership may make the difference in our ability to achieve our objective in an evolved health care system in North Carolina or in the nation.



Margaret C. Yarborough Sims

Margaret "Peggy" Yarborough graduated from the UNC School of Pharmacy where she received her B.S. and M.S. degrees. Currently, Peggy is associate professor, Department of Pharmacy Practice at Campbell University School of Pharmacy, Buies Creek; associate director for pharmacy education, Area L AHEC in Rocky Mount; adjuvant professor at the UNC School of Pharmacy in Chapel Hill; clinical consultant for pharmacy services, Wilson Memorial Hospital in Wilson; and pharmacist clinician, Diabetes Outcome Management Program, Wilson Community Health Center in Wilson. Peggy is founder of Pharmacy Consultation Services and the DIABECC Diabetes Care Center.

In 1993 Peggy was selected by NCPhA as the first NC recipient of the Dupont Pharma Innovative Pharmacy Practice Award. She has also received the American Diabetes Assiciation's Diabetes Educator of the Year Award and the Patient Care Award, the Bowl of Hygeia Award, UNC's Distinguished Alumni Service Award, APhA's Daniel B. Smith Award, and named as a Fellow of the Academy of Pharmacy Practice by APhA.

Peggy is active at both the state and national levels, serving on various committees and boards. Nationally, she is a member of the American Pharmaceutical Association, Board of Pharmaceutical Specialities, American Society of Hospital Pharmacists, American Diabetes Association, American Associaiton of Diabetes Educators, National Certifcation Board for Diabetes Educators. At the state level she is a member of NCPhA, NCSHP, the UNC Alumni Association, and Wake County Pharmaceutical Association. In addition she is active in numerous other civic groups.

"How can NCPhA best meet the needs of the membership as health care reform evolves?"

As pharmacists, we are currently witnessing two exciting events: first, the health care system is changing dramatically and at a rapid pace. Second, our profession is changing just as dramatically and as rapidly. Both changes are labeled as parts of a health care reform movement. However, these were in the making well before health care reform became a buzz word! Even if legislation propelling health care reform fails or slows, changes will still occur and affect our profession, our health system, and our lives.

NCPhA can best serve its membership in the years to come 1. by recognizing that the changes we are witnessing are independent of, yet strongly influenced by, legislation and the activities of other health professions. NCPhA must be proactive, not reactive, to these changes and to the legislative arena in which they will be molded. 2. By disseminating information and continuing education targeted specifically to decision making skills and pharmacy patient care, thereby improving all areas of pharmacy practice. 3. By working for changes that strengthen the roles and responsibilities of pharmacists in drug distribution, drug therapy, and patient care—changes that maximize a pharmacist's expertise as a pharmacist, not just a new health care extender. NCPhA committees, leaders, and individual members must lead the way in working towards this end.

Pharmacy Day

in the

Legislature

February 15, 1995

Radisson Plaza Raleigh

sponsored by the
North Carolina Pharmaceutical Association
and the
North Carolina Society of Hospital Pharmacists

Don't miss this unique opportunity to network with your legislators. Your input is vital to the many important issues facing pharmacy.

Based on the favorable comments from last year's program we expect an excellent turn out. Mark your calendar and make plans to attend.

Watch Your Mail for Details and Registration Information

This is Your Opportunity to Make Your Voice Heard!

WOMAN'S AUXILIARY MID-YEAR REPORT

Greetings from the Woman's Auxiliary of the N.C. Pharmaceutical Association. We have had a very exciting year so far. We began the fall by redecorating the Institute. The redecorating committee has done a fabulous job with our facelift. The offices have new carpet, new window treatments, the ceilings were painted, and the walls were cleaned. Al has a new chair (his other one was falling to pieces!) and new light fixtures in his office. New light fixtures were also put in the board room and the twelve leather chairs were reupholstered. It now looks like an elegant board room!

We hope you have a chance to go by soon and see the beautiful improvements and your contribution at work.

The Woman's Auxiliary awarded five scholarships to UNC pharmacy students this year and one to a Campbell pharmacy student.

Much fun was had by all who attended the Woman's Auxiliary Fall Fun Day held on November 5. We attended a Blue White basketball game and then met at the Institute for a barbecue supper and live entertainment. This event was held in lieu of our Fall Convocation.

We have made some exciting plans for the Annual Woman's Auxililary Convention, being held in conjunction with the NCPhA Convention in Asheville at the Grove Park Inn, May 18-21. Mark your calendar now and make plans to attend. We are looking forward to seeing you there.

Peggy Jackson
President
Woman's Auxiliary of the NCPhA







NORTH CAROLINA PHARMACEUTICAL ASSOCIATION 1994-95 STRATEGIC PLAN

INTRODUCTION

Following is a strategic plan developed by the 1994-95 Executive Committee of the North Carolina Pharmaceutical Association. This plan was developed with grassroots committee input, and we hope it will guide our direction through the coming years.

Top priorities as identified include:

I. Unity/communication
II. Expand pharmaceutical care and reimbursement for cognitive services
III. Increase dues-paying membership
IV. Have a higher legislative profile and get more effective legislative action
V. Advance education programs—expand areas of pharmacy practice
VI. Increase finances (non-dues)
VII. Make Association more responsive to addressing needs of membership
VIII. Get more pharmacists involved in community and political activities
IX. Revise constitution and by-laws
X. Promote benefits of pharmacy services to North Carolina public (public relations)

NORTH CAROLINA PHARMACEUTICAL ASSOCIATION PURPOSE AND OBJECTIVES

Purpose: The purpose of this Association shall be to unite those concerned with pharmacy practice in North Carolina and to advance the profession of pharmacy.

Objectives: The objectives of the Association are:

1. To improve the science and art of pharmacy and to elevate its standards.
2. To assist members of the Association in achieving economic, educational and professional goals.
3. To promote and encourage political action in issues related to pharmacy.
4. To encourage and assist pharmacists in providing pharmaceutical care.
5. To promote the benefits of pharmaceutical care to the North Carolina public.
6. To promote and encourage the research, study, and resolution of issues related to the practice of pharmacy.
7. To promote careers in pharmacy.
8. To support pharmacy education in North Carolina.
9. To provide educational resources to members.
10. To disseminate relevant information to members.
11. To maintain and enforce membership adherence to the North Carolina Pharmaceutical Association's Code of Professional Ethics.
12. To promote and encourage interdisciplinary communication with other health professionals.
13. To support the mission statement for North Carolina Pharmacy.

NORTH CAROLINA PHARMACEUTICAL ASSOCIATION PLANNING OBJECTIVES AND RECOMMENDATIONS

OBJECTIVE 1

To improve the science and art of pharmacy and to elevate its standards.

Current Activities: Legislative action, CE, uniting all aspects of pharmacy for common interest, scholarships and gifts to schools of pharmacy and other educational groups.

Recommendations:

1. To obtain this objective, the Association must stay abreast of changes in the profession and offer better communication with its constituents, involve industry in the Association beyond mere involvement as a means for funding, and develop a means to evaluate the success of this objective.
2. Develop and implement an industry advisory council to advise the Executive Committee. Recruit industry members. There is currently a committee that meets with the Executive Director in confidence and shares information.
3. The Association should make available to members CE programs that respond to patient counseling regulations of the Board of Pharmacy.
4. The Association must insure that CE programs are pertinent. Programs meeting the objectives of the Association should be provided in the Journal, at CE meetings, and at the Convention.
5. There should be a CE Committee to review and approve CE before offering it to the membership. Continue to develop resources in the schools of pharmacy to identify expertise in producing needed CE programs. The CE Committee should be accountable to the Executive Committee.
6. The most important need at present is for the Association to hire a Director of Professional Affairs to oversee the Objectives.

OBJECTIVE 2

To assist members of the Association in achieving economic, educational and professional goals.

Current Activities: CE, insurance programs, assistance with local pharmacy association, Legislative Day, awards.

Recommendations:

1. Stands on its own merit and is high priority.
2. The Association should identify services provided to members and review their necessity, the time and money resources required and the return on investment by membership.
3. Assess what other state Associations are doing. Develop service strategy and value of services provided. Use information from the Executive Director and staff in assessment process.
4. Have the Finance Committee look at areas of revenue generation.

OBJECTIVE 3

To promote and encourage political action in issues related to pharmacy.

Current Activities: Legislative lobbying being conducted by the Executive Director, Legislative Committee, and one part-time lobbyist. The Executive Director generates a phone tree. Publication of information in Journal and Digest and urgent information in Legislative Alert publication. Legislative Day.

Recommendations:

1. Evaluate, modify, and continue NCPhA Pharmacy Legislative Day. Build on event to create a broad grassroots network of legislative contacts by members.
2. Develop a Legislative Model available to local associations for implementing regional versions.
3. Legislative action is a long-range plan. Political alliances take time to develop. Members must maintain contact with and support of legislators on a continuous basis whether key pharmacy issues are in legisla-

ture or not.

4. Political funding of candidates by members is very important.

5. Emphasize importance of NC Pharm PAC to members.

6. Develop a core group of politically active members in the Raleigh area to actively implement lobbying efforts along with Executive Director and Association lobbyist. These members have better opportunity to get to the legislature on short notice.

7. The Association must hire a strong lobbyist on a more permanent basis. It must address the issue of resources to pay for this position.

8. There is a need for the Executive Director and staff to allocate more time to this area, especially when legislature is in session.

9. Develop a job description for lobbyist, including the extent of involvement on issues and the extent of involvement with staff and grassroots mechanism, recruitment, and communication.

10. Develop mechanism for maintaining strong legislative involvement.

OBJECTIVE 4

To encourage and assist pharmacists in providing pharmaceutical care.

Current Activities: Mailings to constituents, involvement with other professional groups; CE at Conventions, publications and seminars: public education including NC Pharmacy Week and public service announcements: and involvement in AHEC and Schools of Pharmacy.

Recommendations:

1. Change "the rational use of medication, therapeutic agents, etc." to "pharmaceutical care". The term of reference should clarify that all of these elements of pharmacy practice are included in pharmaceutical care.

2. The Association needs to work more with other professional groups. It needs a mechanism for evaluation. It should form liaisons with other medical professions to establish long-term relationships—not issue-based discussions.

3. Consider establishment of a certification program for Pharmaceutical Care through the Director of Professional Affairs and supplemental volunteer assistance. Develop modules and create marketing plans for progress. May have problems with national certification.

OBJECTIVE 5

To promote the benefits of pharmaceutical care to the North Carolina public.

Current Activities: NC Pharmacy Week, public service announcements.

Recommendation:

1. The Association can better utilize NC Pharmacy Week to get the message of pharmacy out to the public.

2. The public needs to hear "service" not "cost" as the key to improving health care.

OBJECTIVE 6

To promote and encourage the research, study, and resolution of issues related to the practice of pharmacy.

Current Activities: Research projects with Schools of Pharmacy, addressing regulatory action, Pharmacy Task Forces.

Recommendations:

1. Need to add "resolution" to Objective.

2. The Association needs to develop means to ensure reasonable compensation for pharmacy service—one of the major problems facing the profession.

3. The Association must choose the right battles to fight. We need to be sure the Association is working on the most important problems facing pharmacy.

4. The Association must strengthen the role of Committee work in obtaining this Objective. Make sure the President gives clear directions and the Committees communicate.

5. The Association needs to have a mechanism for conveying action programs to all members. Members need to know the vision

and pro-active positions of the Association.

OBJECTIVE 7

To promote careers in pharmacy.

Current Activities: All questions regarding pharmacy as a career are referred to Schools of Pharmacy.

Recommendations:

1. The Association should keep current educational and promotional packages for each School of Pharmacy.
2. The Association should communicate with high school guidance counselors on an annual basis.

OBJECTIVE 8

To support pharmacy education in North Carolina.

Current Activities: Scholarships, information sharing, involvement with students at state and national meetings, participation in experiential training, staff availability for Schools of Pharmacy activities, lobbying, student orientation, and research.

Recommendations:

1. The Association should involve students in all NCPhA activities, including all committees.
2. There is some limitation in the ability to reach students and the ability to involve students due to their time and monetary restraints.

OBJECTIVE 9

To provide educational resources to members.

Current Activities: CE programs in Journals, seminars, and at the Convention; staff involvement with local pharmacy association, help in developing pharmacy law and regulatory book.

Recommendations:

1. The Association should conduct a CE needs assessment from its members as to content and quality of programs and then structure programs to meet the needs of its members. Make programs available to underserved areas.
2. Assist membership in obtaining extramural, non-traditional Pharm.D.
3. The Association should develop a position on entry-level Pharm.D. It should conduct a survey of its members to determine support. Manpower will be needed to lobby its position at Schools of Pharmacy and the NC Legislature. Is there a need to "grandfather" UNC graduates with BS degrees?

OBJECTIVE 10

To disseminate relevant information to members.

Current Activities: Publications include Journal, Pharmacy Digest, prn publications on priority issues (ie. Legislative Alerts). Toll-free telephone line for ease of communication.

Recommendation:

1. Communication is the backbone of the Association and perception of the value of the Association by its members is measured by the Association's ability to communicate the organization's vision, positions on issues, and achievements of the Association and its members.
2. This is a very tangible membership benefit.
3. Publication timeliness is of utmost importance. The Journal is far behind schedule. The Association must decide to publish less often, combine months, reassign personnel priorities, or hire a Director of Professional Affairs to oversee publications.
4. The Association must reduce computer hardware snafu.
5. Publications should have local pharmacy group reports and pictures of its members in action.
6. Legislative action is a priority. The Association should implement a grassroots political action mechanism. The speed of information sharing is essential. Need phone/FAX network. Study other methods such as electronic bulletin boards. Identify key politically active members and assign liaisons to share intelligence. Identify those who know their legislators and keep list current. Every legislator should have phar-

macist contact. Know the key legislative players. Create legislative alliances.

7. The Association should develop an action plan to overcome member perceptions of secretiveness/clandestine outsider feelings. Avoid questions of "What is NCPhA doing for pharmacy?"

8. The Executive Committee should send agenda, financial reports, and other documents out to its Board one week prior to meeting.

9. Assign both staff and Executive Committee liaisons to Committees.

10. Prepare an organizational chart and job descriptions for all staff, officers and committees with time based assignments to duties.

11. New Committee chairmen should receive notebooks of all old minutes and previous Chairmen's notes for the Committee. They should also receive the purpose of the Committee and the President's charge as to proposed expectations of the Committee.

12. An Annual Report, including all Annual Committee Reports, should be provided to all members.

13. Changes in the Association should come from an action plan developed from a comprehensive strategic plan to get more productivity out of Committees and to measure achievements.

14. The Association should develop an officer's handbook, including roles and responsibilities.

15. The Association should hold periodic Leadership Training Seminars for its Officers and Committee Chairmen.

16. The Association should develop a yearly calendar of events.

17. The Association should develop a policy flow chart on how policy is made within the Association from grassroots requests, to let members know how they can have input into policy making.

18. There should be a mechanism to follow-up on implementation of all resolutions passed at the annual Convention.

19. The Association should look at the Convention format to develop a mechanism for communicating "what's going on in NCPhA."

20. The Association should create a Communicating Committee to oversee this Objective. It could be combined with the CE Committee. A subcommittee of this group could be an Editorial Advisory Board.

21. Possibility of charging a fee for processing CE in Journal as a resource.

22. The Association should conduct a needs-assessment survey of its membership and have focus groups to discuss member needs and Association services.

23. Establish an Educational Advisory Board to represent a cross-section of members.

24. Pharmacy Digest has too much information. It should only focus on key issues.

25. The Association should publish Executive Committee minutes.

26. Explore the use of information phone FAX.

27. Address problem of internal communication between staff, officers, Committee chairmen, and Committee members. Form task force of staff and members to address this issue.

28. Develop more efficient communication to benefit the Association.

29. Create a Convention Planning Committee.

30. Create a Presidential Planning Committee to set action agenda for the year.

31. Emphasize NC Pharmacy Week.

32. Create a Membership Committee or Task Force to recruit and retain members and survey their needs.

33. Redefine the entire Committee structure. Should there be deletions? Possible combinations of Public Health and Mental Health, State Government and Third Party.

OBJECTIVE 11

To maintain and enforce membership adherence to the North Carolina Pharmaceutical Association's Code of Professional Ethics.

Current Activities: Few actions have been taken to enforce this Objective.

Recommendations:

1. Look at APhA Code of Ethics. Is there a need to adopt it?
2. Keep updated Code of Ethics in place.
3. Develop written guidelines.
4. Deemphasize judicial and emphasize integrity/guidelines issues.

OBJECTIVE 12

To promote and encourage interdisciplinary communication with other health professionals.

Current Activities: Primarily involves the Executive Director. He meets with NC Medical Society and other health groups on periodic basis.

Recommendations:

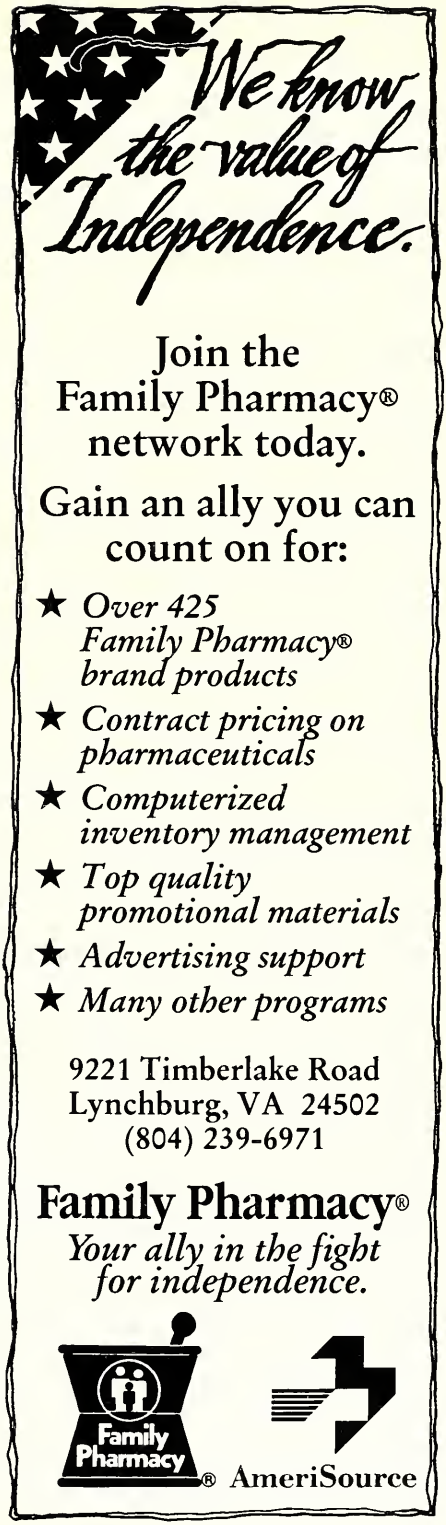
1. Could go under "Image" Objective.
2. Need to identify alliance groups and work to bridge communication barriers.
3. Need to look at long-term relationships.

OBJECTIVE 13

To support the mission statement for North Carolina pharmacy.

Current Activities: Adopted May 24, 1991

Recommendations: None



AROUND THE STATE

Burnsville—**Charles Gillespie** and Pollard's Drug Store were recently named recipient of the first-ever Business Citizenship Award. The award and certificate were preented by the Yancey County Chamber of Commerce in a surprise ceremony.

Chapel Hill—**Fred Eckel** has been named the new executive director of Christian Pharmacists Fellowship International (CPFI) Fred is also a past president of CPFI.

WEDDINGS

Zebulon—**Emily Dawn Pulley** wed Charles Carter on September 17. Charles and Emily are graduates of the UNC School of Pharmacy. Emily is a pharmacist at Southeaster Regional Medical Center. Charles is a pharmacist with Revco in Red Springs.

BIRTHS

Cherryville—**Roy** and **Alisa Hill** anounce the birth of a son, Jonathan Luke Hill. Jonathan, born on December 5, weighed 8 lbs, 8 ozs. Roy and Alisa are graduates of the UNC School of Pharmacy.

FROM THE SCHOOLS

Campbell University School of Pharmacy

As the fall semestercame to a close, nine faculty and twenty students from Campbell attended the ASHP Midyear Clinical Meeting in Miami Beach in December. A reception for Campbell Pharmacy Alumni attracted over twenty alumni in addition to the faculty and students. This was the first event of this type for the new school of pharmacy at a major national professional meeting. The drug information residency program, which was site-visited for accreditation by ASHP in November, was displayed in the residency showcase—another first for this program.

The spring semester is fully underway. Twenty-eight employers representing all facets of the pharmacy profession were present on campus on January 13 for the sixth annual career day. They interviewed sixty-five of the graduating seniors. It was great having our seniors back on campus in the midst of their clerkship experiences.

The APhA-USP National Patient Counseling Competition has begun in earnest. P-3 student Kristen Thomas, last year's national winner, is spearheading the organization of this activity.

We are looking forward to sending a good delegation of students and faculty to the Pharmacy Day in the Legislature and to the presentations of two featured speakers coming to campus. Dr. Jean Gagnon, from Marion Merrell Dow, will be speaking to the students on pharmacy's future and Dr. Cal Knowlton, president-elect of APhA, will be with us in early March to address some practical aspects of implementing pharmaceutical care.

Submitted by Larry Swanson, Professor and Chairman, Department of Pharmacy Practice, Campbell University School of Pharmacy, Buies Creek.

UNC School of Pharmacy

The faculty of the UNC School of Pharmacy held a retreat at the Friday Center on January 7, 1995. Athe meeting, which lasted all day, the upcoming $2.5 million renovation project to Beard Hall was discussed. This process will begin in early April and proceed for fourteen months. It will affect the basement, second and third floors and is designed primarily to increase the safety of the building.

The Building Campaign for additional space adjacent to Beard Hall is in the planning stages. The co-chairs of the campaign are George Abercrombie '78, Keith Fearing '44, and Seymour Holt '53. Already $750,000 has been committed to the campaign and other gifts are being sought for the $5 million private goal. The other $10 million will be sought from state government funds to build the $15 million, $55,000 sq. ft. facility.

The topic of the external Pharm.D. program was discussed at length. The faculty is committed to providing the opportunity for working pharmacists to pursue their Pharm.D. degree and has approved a curriculum that should be implemented in Fall 1995. Details will be forthcoming.

We have received almost 600 applicants for entry into the School of Pharmacy for Fall 1995. Many candidates have already been interviewed and with only 160 available positions, competition is great. We are fortunate to have an excellent pool and we thank many alumni who encourage excellent students toward the profession of pharmacy.

Submitted by Kevin Almond, Assistant Dean, UNC School of Pharmacy, Chapel Hill

"OCCURENCE" MALPRACTICE INSURANCE NOW AVAILABLE THRU NCPhA

The North Carolina Pharmaceutical Association is now endorsing the Cincinnati Insurance Company of Cincinnati, Ohio. This is a reputable company with over 50 years in the business.

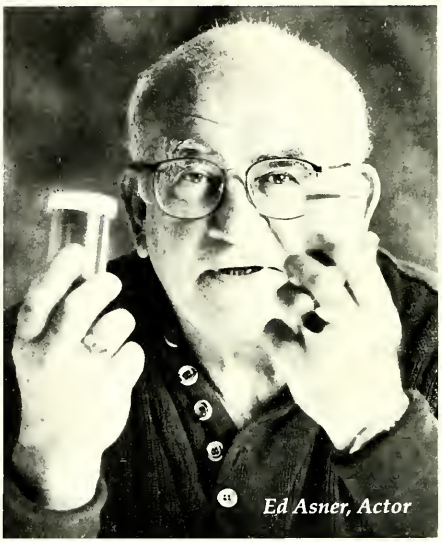
NCPhA is pleased to offer this insurance, which is an occurence plan, to our members for the low rate of **$160 per year***. This particular plan offers **1,000,000 per claim with 1,000,000 aggregate.**

The plan is designed for NC employee pharmacists. Pharmacy owners and pharmacists residing and working outside of NC are not eligible for this plan.

☛ *If you would like to receive an application please contact Terri at the NCPhA office at 1-800-852-7343.*

**rate guaranteed for three years*

Attention: Pharmacists



Have your patients' medicines had a check-up?

Many of your patients take several different medicines every day. Separately each one works well. But if they take two or more different medicines in combination without checking with you to be sure they work safely together, they can sometimes be harmful...even dangerous.

The next time you counsel about medicines, be sure to ask:

"What other prescription and nonprescription medicines are you taking?"

YES! Please send me free information to use when talking with my patients about their multiple medicine use

Name

Address

City State Zipcode

Mail to:
NCPIE
666 Eleventh Street, NW
Suite 810
Washington, DC 20001

OR FAX: (202)638-0775

A public service message from the National Council on Patient Information and Education (NCPIE) and the U.S. Administration on Aging

CORRESPONDENCE COURSE

PATIENT COUNSELING: OTC TOPICAL HYDROCORTISONE PRODUCTS



Thomas A. Gossel, R.Ph., Ph.D.
Professor of Pharmacology and Toxicology
Ohio Northern University
Ada, Ohio



J. Richard Wuest, Pharm.D.
Professor of Pharmacy Practice
University of Cincinnati
Cincinnati, Ohio

Goals

The goals of this lesson are to discuss important therapeutic principles concerning the topical use of hydrocortisone used for self-treatment of dermatologic conditions, and to present information to use when counseling patients on its use.

Objectives

At the completion of this lesson, successful participants should be able to:

1. identify the mechanism of action of corticosteroids when used for topical anti-inflammatory action;
2. recognize adverse effects reported for topical corticosteroids;
3. choose appropriate products when a particular dosage form is requested;
4. select a suitable dosage form based on the intended use of the product; and,
5. pick from a list information appropriate to convey to patients about the topical use of hydrocortisone.

The availability of products containing hydrocortisone that can be purchased without a prescription has been a major triumph in therapy. The list of topical skin problems that benefit from the use of these products is extensive.

A primary goal of topical hydrocortisone therapy is to maximize its clinical response while minimizing adverse effects. There is no doubt that OTC topical hydrocortisone-containing products confer significant therapeutic activity. Nonetheless, pharmacists have expressed concern about their safety when used without physician supervision for long periods of time.

Background

Hydrocortisone has been available in the U.S. as a prescription drug since 1952. After passage of the Durham Humphrey Amendment to the Pure Food, Drug and Cosmetic Act, which differentiated prescriptions and OTC status was denied. FDA felt there was

insufficient evidence of safety without medical supervision to warrant nonprescription availability.

Then in 1979, an FDA/OTC advisory panel recommended that hydrocortisone and hydrocortisone acetate (hereafter referred to as hydrocortisone) be categorized as safe and effective for self-medication of itching at concentrations up to 0.5 percent from Rx-only to OTC status. Its decision was based on the presumption that the benefits of OTC availability outweighed the risks of potential misuse. Numerous OTC products were marketed for use as antipruritics, and they received immediate consumer acceptance.

By the end of the first two years of OTC availability, the products were estimated to have saved the American health care system approximately $600 million. This savings was achieved in reduced physicians' fees, fewer lost work days, and lower medication costs. During the years of OTC marketing hydrocortisone in a maximum strength of 0.5 percent, more than 130 million units were purchased. More recently, FDA has raised the upper limit of OTC products to 1 percent. This had been approved in several other countries including Sweden (1983), Denmark (1984), Norway (1985), and Great Britain (1986), without reports of toxicities. Furthermore, it was shown from the experience of consumers and from data reported in clinical trials in the U.S. and elsewhere that hydrocortisone is safe. However, data were also presented to confirm that the 0.5 percent-strength products did not provide optimal therapy in all individuals for the conditions for which it was indicated. In seven controlled studies involving over 4,000 subjects, 1 percent hydrocortisone was shown to be more effective than 0.5 percent. It was, therefore, suggested that the stronger concentrations could benefit a greater number of consumers.

Mechanism of Action

Topically-applied hydrocortisone is believed to act, in part, by binding to steroid receptors within the cytoplasm and/or on the outside of the cell's nuclear membrane. This forms complexes that penetrate the cell nucleus, bind with DNA, and modify transcription of mRNA (messenger RNA-the "road map" of cellular activity). This leads to the synthesis of proteins that have beneficial therapeutic action, such as anti-inflammatory activity in inflamed cells.

Hydrocortisone also modifies the inflammatory process by an action on release and function of chemical mediators of inflammation such as histamine and quinines which stabilize lysosomal membranes. This action suppresses release of the cells' destructive enzymes. There is evidence that corticosteroids induce production of lipocortin, an inhibitor of the enzyme phospholipase A_2. This, in turn, inhibits synthesis of prostaglandins, leukotrienes, and platelet activation factor, all of which are part of the body's inflammatory response to trauma and foreign materials. The therapeutic action of corticosteroids is nonspecific, because it is exhibited against most causes of inflammation, i.e., chemical, mechanical, and immunological.

Some experts state that vasoconstriction is a major component of topical hydrocortisone action. This prevents mobilization of polymorphonuclear leukocytes and monocytes into the area of inflammation. These are two scavenger cell-types that add to the inflammatory response. However, other authorities dispute the claim that vasoconstriction is not a consistent component of hydrocortisone's action. They state that significant vasoconstriction is seen in fewer than 10 percent of subjects tested.

Therapeutic Profile

Hydrocortisone is the benchmark against which safety and effectiveness of all topical corticosteroids are measured. It has received the widest recognition, and has been used most extensively in therapy of inflammatory skin disorders. Studies that compare the relative potency of various corticosteroids traditionally rank hydrocortisone as a low-potency anti-inflammatory steroid. At the same time, hydrocortisone ranks high on safety. These properties make it ideal for

self-administration.

Safety. Some well-known adverse effects associated with more potent topical corticosteroids include iatrogenic (i.e., drug-induced) Cushing's syndrome, appearance of striae (streaks or lines on the skin) if the steroid is used on the face, and corticosteroid dependence. However, these adverse effects have not been documented for hydrocortisone.

When hydrocortisone is applied to normal skin, only 1 percent or less of the drug is absorbed through damaged skin. The extent of absorption is dependent, at least in part, on the site of application. It has been demonstrated that absorption of topically applied hydrocortisone, expressed as a ratio where absorption on the forearm equalled 1.0, ranged from 0.14 on the foot arch, 3.5 on the scalp, 6.0 on the forehead, 13 on the jaw angle, and 42 on the scrotum. Even if the improbable "worse case" scenario occurred whereby an individual absorbed the entire contents of a one ounce tube of 1 percent hydrocortisone, only 300 mg could reach the systemic circulation. This quantity is only slightly greater than the approved initial oral dose of 240 mg/day for hydrocortisone, and equal to that of hydrocortisone acetate.

Children under 2 years of age who have severe widespread dermatitis are not candidates for unsupervised hydrocortisone application. Absorption is enhanced in infants. Therefore, hydrocortisone for diaper rash must also appear on the label.

Absorption may be enhanced ten-fold by increasing the skin's humidity and forcing movement of a drug through the skin with an occlusive covering. Tightly-fitting clothing, and ointment-based vehicles may also occlude the skin and enhance absorption.

A summary of adverse reactions for both Rx- and OTC single entity hydrocortisone products reported for the two decades between 1970 and 1989 included 724 accounts. Of these, only 207 were associated with topical use of hydrocortisone in varying strengths of 0.25 percent to 2.5 percent. Virtually all of the adverse drug reactions were of a local nature, with contact dermatitis (61 reports), allergic reactions (48 reports), rash (33 reports), application site reactions (23 reports), and pain and pruritus (29 reports) occurring most frequently. In three persons who were hospitalized from using a product containing 0.5 percent hydrocortisone, the product was not used according to instructions. Two of the reactions involved exacerbation of an existing infection. The third included an incidence of bullous erytherm multiforme (a symptom complex characterized by vivid blisters and lesions which appear suddenly in a symmetrical distribution) that occurred when the product was placed on a scratch and a blister, then occluded with a bandage.

If one examines the case studies that report on adverse effects, it can be seen that the reactions described for drug products containing 0.5 percent and 1 percent hydrocortisone are similar qualitatively and quantitatively. The stronger strength does not result in more hazardous outcomes. Moreover, many, if not most, irritation and sensitization reaction from hydrocortisone products are believed to be caused by the vehicle.

Approved Uses

Hydrocortisone topical products available without a prescription are safe and effective for self-treatment of the symptoms of self-limiting skin disorders. The FDA approved indications are temporary relief of itching associated with minor skin irritations, inflammation and rashes due to eczema, psoriasis, seborrheic dermatitis, poison ivy, poison oak, poison sumac, insect bites, soaps, detergents, cosmetics, and jewelry, and for external feminine and anal itching.

To briefly describe these conditions, the term eczema is used interchangeably with dermatitis. They describe mild inflammation (often with redness and discoloration of the skin) of unknown cause.

Psoriasis and seborrheic dermatitis involve inflammation and discoloration, and also exhibit scaly patches of skin. They are the result of excessive proliferation of keratin

Table 1
Representative OTC Products Containing Hydrocortisone

Trade Name (Manufacturer)	Dosage Forms Cream	Ointment	Lotion	Aerosol/Spray
Bactine Hydrocortisone (Miles Labs)	X			
Caldecort Anti-Itch (Fisons)	X			X
Cortaid (Upjohn)	X	X	X	X
Cortef Feminine Itch (Upjohn)	X			
Cortizone-5 (Thompson Medical)	X	X		
Dermolate Anti-Itch (Schering Plough)	X			X
Dermtex HC (Pfeiffer)	X			
Gynecort (Combe)	X			
Lanacort (Combe)	X	X		

cells and overactive sebaceous glands. Symptoms of mild conditions are self-treatable, but moderate to severe problems require physician intervention and systemic treatment.

Poison ivy, oak and sumac describe a variety of plants (over 50 have been identified) that cause allergic reactions on contact. The reactions result in raised lesions that accumulate fluid. The treatment includes topical hydrocortisone for the symptoms of mild cases and systemic corticosteroids for severe conditions. The same is true for insect bites.

In patients who use hydrocortisone solely to alleviate symptoms, rather than effect a cure, rebound of symptoms upon cessation of therapy is not expected. Reports of relapse often involve patients with dermatologic disorders more severe than the indications for OTC use. When patients do not obtain the expected relief from OTC hydrocortisone products, or when the symptoms persist or recur after use, physician intervention is necessary. Professional diagnosis and therapy with one of the more potent fluorinated corticosteroids may be required. These drugs penetrate deeper into the dermal areas and increase the possibility of systemic absorption with resulting side effects not seen with topical hydrocortisone.

Counseling Tips

Approval of hydrocortisone for nonprescription use was one of the more significant advancements in self-therapy of many dermatologic conditions. OTC products (Table 1) containing hydrocortisone are safe and effective when used properly. They are best applied in a thin layer, usually 4 to 6 times daily.

Dermatologic afflictions such as insect bites and poison ivy rash are relatively easy to identify. Verification of some others is more challenging. In face, for some conditions such as viral infections (e.g., herpes and warts) and bacterial infections (e.g., acne vulgaris), the condition may be aggra-

Table 2
Use of dosage Forms Based on Clinical Settings

Dosage Form	Glabrous* non-hairy	Hairy areas	Palms & soles	Intertriginous** areas
Ointment	XXX		XXX	
Cream	XX	X	XX	XX
Lotion		XX		XX
Solution/aerosol		XXX		XXX
Gel		XX		X

XXX Preferred dosage form
XX Acceptable dosage form
X Sometimes-used dosage form

*Glabrous: smooth and bare skin
** Intertriginous: skin that rubs against other skin

vated by topically applied hydrocortisone.

OTC products containing hydrocortisone should not be recommended for treatment of conditions when the cause is uncertain, or when they are long-standing. These require physician diagnosis and treatment.

When recommending hydrocortisone products, the lower-strength products will work satisfactorily for most minor skin afflictions and can be tried first. If they do not provide adequate relief of symptoms within 2 to 3 days, a product containing 1 percent hydrocortisone may provide relief. If the condition does not clear after 7 days of use, physician intervention should be recommended.

The dosage form can make a significant difference in response to the medication. Table 2 summarizes the suitability of various topical formulations based on the affected area.

Cream dosage forms are most often used because of favorable cosmetic acceptance. They are non-greasy, rub in easily, and do not leave a residue. Creams are appropriate for nearly all dermatologic conditions, and can be applied to any area of the body. Lotions are best for chafed areas, and for the scalp or other hairy areas because they spread easily. Sprays are preferred for application to large areas of the skin. Ointments are best used for dry, scaly lesions since they are emollient and retain moisture on the skin providing protection and lubrication.

Satisfactory relief of itching may not be achieved for the first few days after hydrocortisone is applied. Nonetheless, patients should continue to apply the product for 7 days. Another antipruritic remedy containing a local anesthetic or antihistamine, rubbing alcohol, or wet dressings can also be used to control symptoms.

Patient Counseling for OTC Topical Hydrocortisone

1. Topical hydrocortisone is used for temporary relief of minor skin irritation, itching and rashes due to eczema, psoriasis, seborrheic dermatitis, poison ivy, oak, or sumac, insect bites, soaps, detergents, cosmetics or jewelry, or, for feminine and anal itching.

2. To properly use this product:

- Wash your hands before and after use.
- Cleanse the skin area with soap and water and pat dry each time you are ready to apply this medicine, unless directed otherwise by your doctor.
- Only the medicine that is actually touching the skin will work. A thick layer is not more effective than a thin layer.
- Creams, Ointments and Lotions: Apply a small amount of the medicine to the affected

area and spread lightly.

• Lotions and Aerosols: Shake the container well before applying the medicine.

• Aerosols: Hold the container straight up, about 6 to 8 inches from the affected skin area and spray for 2 to 3 seconds.

3. This product is for EXTERNAL USE on the skin only. DO NOT apply it into or near your eyes or mouth.

4. DO NOT apply other creams, lotions or cosmetics on top of or underneath this medicine.

5. DO NOT bandage the area unless directed by your doctor.

6. If your condition persists or worsens, or if you have a constant irritation, such as burning or itching that was not present before you started this medicine, call your doctor.

7. DO NOT use more often or longer than recommended on the label.

8. Read all labels before using this product. If you have any questions, ask your doctor or pharmacists.

9. Keep all medicines out of the reach of children and DO NOT keep or use outdated medicines.

Adapted from the pharmex PALs (*patient advisory leaflets*). *For more information, call* 1-800-233-0585.

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CORRESPONDENCE COURSE QUIZ

Patient Counseling: OTC Topical Hydrocortisone Products

1. FDA originally placed topical hydrocortisone in the Rx-only status because:

a. there was no way to approve OTC drugs when it was introduced.

b. there was insufficient evidence of safety for its use without medical supervision.

c. there was evidence that it was too toxic when used for long periods of time.

d. there were no conditions for which it could be used.

2. Hydrocortisone is the best described as being a:

a. low-potency steroid.

b. intermediate-potency steroid.

c. ultra high-potency steroid.

3. When switched to OTC status, the original upper limit for OTC topical products was:

a. 0.1 percent.

b. 0.25 percent.

c. 0.5 percent.

d. 1 percent.

4. FDA has approved marketing of OTC topical hydrocortisone products for which of the following indications?

a. Bleeding

b. Infections

c. Itching

d. Pain

5. All of the following are believed to be part of the action of topical hydrocortisone EXCEPT:

a. modifying transcription of mRNA.

b. decreasing the release of histamine.

c. suppressing the release of destructive enzymes.

d. increasing prostaglandin synthesis.

6. The term iatrogenic refers to adverse effects that:
a. are drug-induced.
b. affect developing fetuses.
c. are psychosomatic.
d. have no symptoms.

7. Which of the following dosage forms is best for use on chafed areas, the scalp and other hairy areas?
a. Cream
b. Lotion
c. Ointment
d. Salve

8. OTC topical hydrocortisone products must contain a warning against their use for:
a. anal itching.
b. diaper rash.
c. eczema.
d. seborrheic dermatitis.

9. The type of scavenger cell that adds to the inflammatory response is the:
a. platelet.
b. erythrocyte.
c. leukocyte.
d. thromboyte.

10. Which of the following is an appropriate condition for recommending the use of an OTC topical hydrocortisone product?
a. Herpes
b. Warts
c. Acne vulgaris
d. Poison sumac

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CONTINUING PHARMACEUTICAL EDUCATION (CPE)

Patient Counseling: OTC Topical Hydrocortisone Products

- Attach a mailing label from *The Carolina Journal of Pharmacy* or print your name and address and mail with payment of $7.00 to CE Test, NCPhA, P.O. Box 151, Chapel Hill, NC 27514–0151
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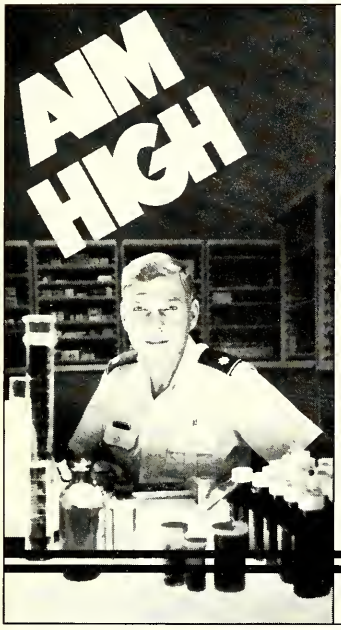
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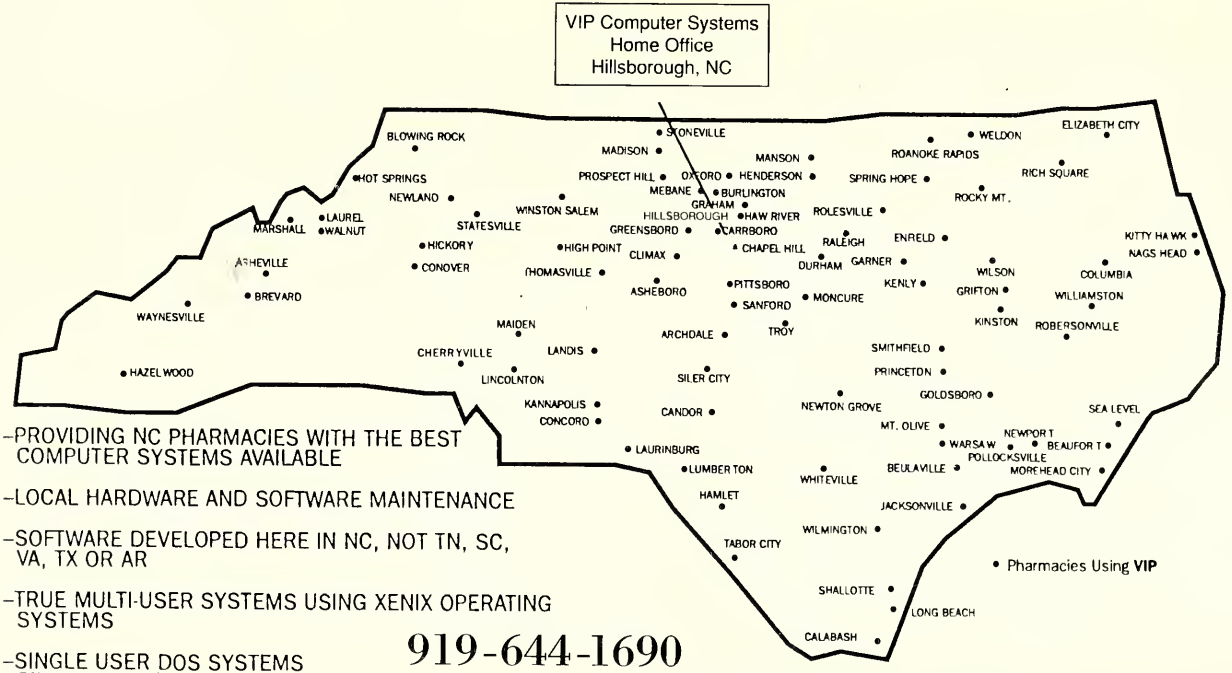
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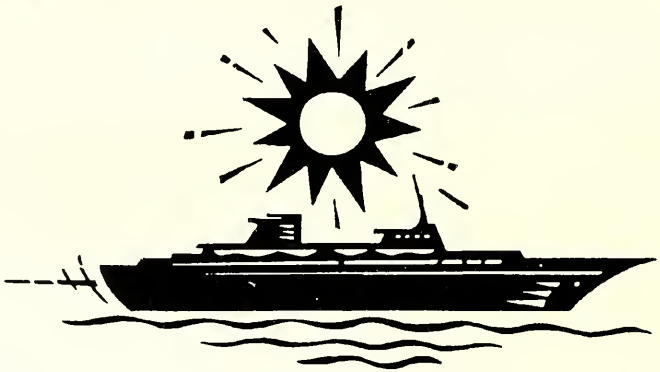
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JOURNAL OF PHARMACY

(USPS 091-280)

March/April 1995 **Volume 75** **Number 2**

ISSN 0528-1725

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The Carolina Journal of Pharmacy is published bimonthly by the North Carolina Pharmaceutical Association, P.O. Box 151, Chapel Hill, NC 27514. *The Journal* is provided to NCPhA members through allocation of annual dues. Subscription rate to non-pharmacists is $25.00 (continental U.S.). Overseas rates on request. Second class postage paid at Chapel Hill, NC.

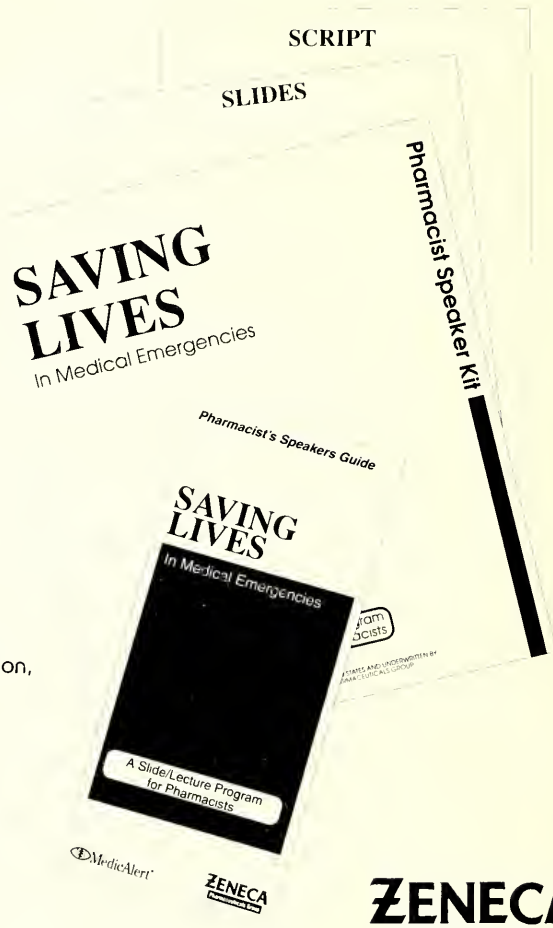
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PRESIDENT'S MESSAGE

THE EIGHTH PERCENT

This is the Convention issue of the *Carolina Journal of Pharmacy*, and it is time to reflect on our Association's achievements during this administration and explain where the NCPhA is concentrating its efforts. We all know the statistics of health care in the United States by heart. Drugs account for 7%, pharmacists account for only 1% of the total. This seems like a small percentage, but it has been adequate in the past to insure quality health care and reasonable reimbursement for the pharmacist. In the past several years, Health Care Reform has changed the course of professional practice permanently. I feel that the federal and state governments have acted too fast and in many cases very foolishly. To a great extent, the 1994 election results reflect the nation's discontent with the notion that more government is better and that the health care delivery system in America is broken. Yet, much of the damage has been done. Shrinking prescription margins, endless paperwork, and the negative effects of managed care are resulting in less care for the patient rather than more. What is the answer that pharmacists can give for better patient care and lower costs for health care providers?

The NCPhA is working in two distinct areas to come up with the solution. First is the development of Pharmaceutical Care training and models of practice. The Pharmaceutical Care Showcase on April 1st and 2nd will demonstrate many of the models now available for implementing the pharmacy practice of the future. The 1995 NCPhA Convention will expand these models of practice even further. The theme "Pharmaceutical Care: Passport to the Future" is certainly appropriate since it is the future we are in the process of developing. Our Association's Pharmaceutical Care and Compensation



Joseph A. Edwards Jr.
1994–95 NCPhA President

Committee is developing not only models of care, but also ways of reimbursement for this quality care. I applaud every member of this committee for the diligence, perserverance, and professionalism they have demonstrated. Great efforts are being made in all segments of pharmacy to gain the professional training needed to take on the new opportunities in providing primary health care. Extramural Pharm.D. programs, certification programs in many specialty areas of practice, redesign of pharmacies to better serve the patient, and training programs in communication and teaching are being developed. All of these efforts are prerequisites for pharmacists assuming more responsibility for optimal therapeutic outcomes for their patients. Statistics have already proven the cost savings associated with better pharmaceutical care—fewer hospitalizations, fewer emergency room visits, less absenteeism, and a higher quality of life.

The second part of the solution for better patient care is in the certification of pharmacists as primary health care providers in

the state. The NCPhA is putting much of its legislative effort in this area. Once this is accomplished legislatively, we can then focus on reimbursement for providing pharmaceutical care. The pharmacist will then be prepared to fully integrate the pharmaceutical care practice—from asthma training to diabetes education, from pharmacokinetics counseling to development of protocols as physician extenders. The possibilities are endless.

This scenario is not only possible, it is going to happen. The momentum of health care has swung back to the pharmacist as a provider of quality professional service and true cost savings. We, as pharmacists, have beat ourselves up and wasted too much time in worrying about the shrinking 1% of our share of the health care dollar and the pharmaceutical manufacturers' expanding 6%. We have complained, pointed fingers, and blamed everyone but ourselves. To this I say enough is enough. No one in pharmacy is the enemy. We are all on the same team. As one of the leaders of this team, the NCPhA is committed to creating a mechanism for pharmacists to capture its fair share of the other 93% of the health care dollar. This is the solution that makes the most sense. We should concentrate our efforts on gaining just one more percent of the health care dollar (the eighth percent) and in return possibly save another 10% for the American health care delivery system. We can all work together to make this happen. See you at the hoedown in Asheville! Ya'll come now, ya hear?

ATTENTION PHARMACISTS LICENSED 50 YEARS OR MORE

If you have been a pharmacist for 50 years or more—licensed in 1944 or earlier—you are eligible for induction into the 50-plus Club. Inductees will be recognized at the Awards Session on Thursday, May 18, during the 115th NCPhA Annual Convention at the Grove Park Inn in Asheville, NC. Friends and family are welcome.

Contact the NCPhA office if you qualify for "membership" in this elite group of pharmacists who have served their profession for 50-plus years. Call 800-852-7343.

CALL FOR RESOLUTIONS

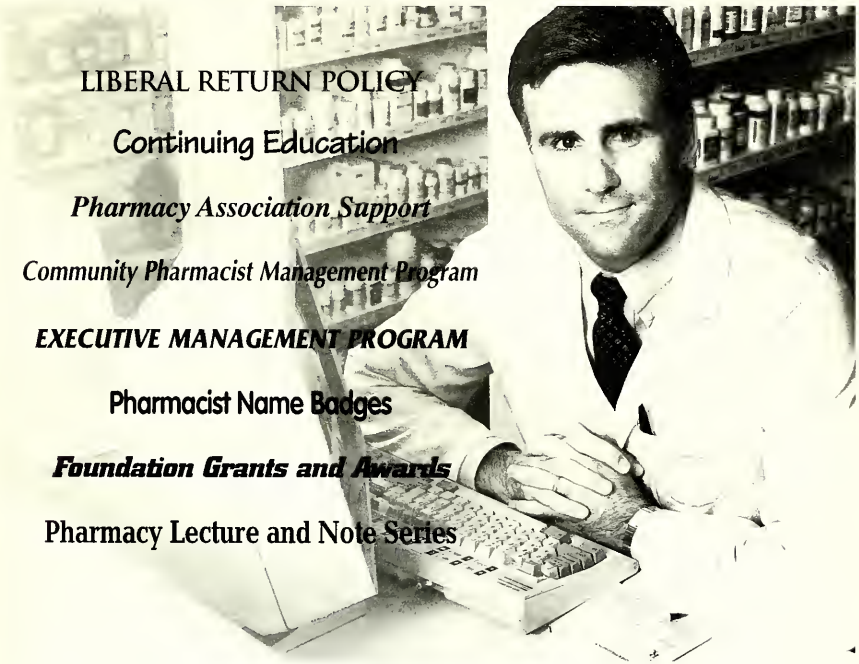
Resolutions from NCPhA members may be submitted for study or action at the 115th NCPhA Annual Convention. Resolutions help guide NCPhA policy, planning, and actions. Each resolution is reviewed in advance by the Resolutions Committee for appropriateness and form. Resolutions are presented by the Resolutions Committee to the NCPhA membership during the 1st and 2nd General Sessions. You may submit your resolution in writing by May 10, 1995 to:

Phil Crouch, Chairman
16 Trinity Chapel Road
Asheville, NC 28805
(704) 252-7636

What pharmacists may think about SmithKline Beecham Pharmaceuticals



What pharmacists ought to know...



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Philadelphia, PA 19101



Joseph A. Edwards Jr.
1994-95 NCPhA President



Peggy Jackson
President, WA



Charles W. Black
President, TMA



The Grove Park Inn, Asheville, North Carolina. Site of the 115th Annual Convention of the NCPhA and affiliated auxiliaries.

115th Annual Convention of the NCPhA and Affiliated Auxiliaries

"Mountain of Opportunities"



The NCPhA Planning Committee asked past convention attendees "How can we enhance the NCPhA Convention?" The answer was was loud and clear—"More CE!" We've listened to your requests and are responding with a well-planned convention program sure to meet the needs and expectations of pharmacists in all practice settings. **Thirteen hours (13 hrs.) of ACPE Continuing Education** can be obtained by attending the NCPhA General Sessions and workshops during the 115th NCPhA Annual Convention, May 18-21, 1995.

A special continuing education session has been added to this year's convention program. **Pharmaceutical Care—Showcase of Activities in North Carolina** will be presented on Thursday, May 18, from 1:00–4:00 p.m. A panel of six North Carolina pharmacists from various practice settings will present models of pharmaceutical care and continuity of care practices designed to encourage growth and development of pharmaceutical care throughout North Carolina.

Awards will be presented to deserving pharmacists at the Awards Session on Thursday, May 18 and later that evening during the Opening Session Banquet.



An Awards Reception honoring the award recipients will follow the Awards Session on Thursday, May 18, from 6:00 p.m.–7:00 p.m. **Charles M. West, P.D.**, executive vice president of NARD and our keynote speaker will share his valuable insight on pharmacy from a national perspective during the Opening Banquet, Thursday, May 19.



Bill G. Felkey, Assistant Pharmacy Professor of Pharmacy Care Systems at Auburn University, Alabama, will present **"While I'm Doing Pharmaceutical Care, What's My Computer Supposed to be Doing"** during the 1st General Session on Friday, May 19. During this Session, Bill will build on the current knowledge of the participants by providing a review of current developments in pharmacy automation, the evaluation of current software applications, and issues raised for the future of pharmacy practice and health care. Technological advances in the pharmacy field are sweeping our nation. Don't miss this opportunity as Bill shares valuable insights on these developments and how you can put these advances to work in your practice setting.

Exhibitor's Fair and Apron Luncheon. Enjoy a delicious lunch neatly tucked into the pockets of a souvenir apron as you browse through the exhibits on Friday, May 19. Does this spark an idea for your own "Apron Lunch" on those busy days in the pharmacy?



Don yer favorite western duds and mosey on down to the hoedown at the ranch, that is **Taylor Ranch**. On **Friday, May**

19 we'll party "mountain style." The evening will feature a "Country Bash Buffet," a little do-si-do (that's square dancing for you city slickers), a country band, and country line dancing—complete with line dancing instruction. Plan to attend what's sure to be the best thing since Lydia Pinkam's came on the market.

June H. McDermott, M.S., M.B.A., Clinical Assistant Professor at UNC School of Pharmacy, Chapel Hill and **Michael V. Rogers, Pharm.D.**, Dr. Rogers OTC Homeopathic Medicines, will talk on **"Homeopathy and Herbal Medicines"** at the 2nd General Session on Saturday, May 20. Mike and June will share the medicinal value of a few homeopathic and herbal medicines. In addition, they will share information on homeopathic and herbal medicines application to practice, dosage forms, remedies, and the proper approach to counseling patients regarding the use of these resources.



Financial Strategies for the '90s, will be presented on Saturday, May 20 by American Express Financial Advisor, **Lydia Woody.** This workshop will cover a broad range of financial topics such as, financial planning for immediate needs, retirement, education of children, minimizing taxes, estate planning, financial strategies for the business owner, and more!

Molly A. Scott, Pharm.D., Asst. Professor of Pharmacy Practice at Campbell University will present a workshop on **Drug Induced Disease** on **Saturday, May 20.** The workshop will cover general principles of drug induced disease and present specific case studies, including drug-induced hepatic disease, drug-induced hematological disease and drug-induced renal disease. In addition,



the appropriate monitoring and management of drug-induced disease will be discussed. Plan to attend this informative workshop!

Back by popular demand is **Jim Morrison**, President of The Company in Overland Park, Kansas. Jim will once again present a workshop geared towards pharmacists in practice 10 years or less on Saturday, May 20. In his presentation, **Leadership Training for the Young Pharmacist**, Jim will share techniques that will help pharmacists develop their leadership skills in pharmacy practice and professional organizations.



The Convention will wind down Sunday, May 21, on a big note. During the Final Session, **T. Donald Marsh, Pharm.D.**, Director of the Mountain AHEC in Asheville will present **New Drugs**. Don will discuss new agents which entered the U.S. drug market for treating depression that offer significant pharmacotherapeutic advantages over older agents. In addition, he will speak about the mechanisms of action of these agents, typical dose(s) used, common side effects, adverse reactions, and more!

In the second half of the Final Session, **Wesley G. Byerly, Pharm.D.**, Director, Drug Information Services at NC Baptist Hospital, will present **New Uses for Old Drugs**. Wes will cover new therapeutic indications for select marketed medications.

The stage is set for the grandest of all NCPhA Conventions and a space has been reserved just for you! Plan now to join us May 18–21, 1995 in the majestic moutains of Asheville, North Carolina.

For more information call the NCPhA office at



1-800-852-7343



"Coastline" from Charlotte will be the featured band at the T.M.A. Dance, Saturday, May 20. Join us as we dance the night away!



115th Annual NCPhA Convention
May 18–21, 1995
The Grove Park Inn, Asheville
PROGRAM

THURSDAY, MAY 18, 1995

1:00–4:00pm **Pharmaceutical Care—Showcase of Activities in North Carolina ••3hrs ACPE #188-088-95-008••**

Jennifer L. Burch, Pharm.D.
Staff Pharmacist
Central Pharmacy

Debra P. Futrell, Pharm.D.
Clinical Pharmacist
Roanoke Amarantha Community Health Group, Jackson

Timothy J. Kurek, Pharm.D.
Director of Pharmacy
Kaiser Permanente, Morrisville

Maryann S. Restino, Pharm.D.
Pharmacy Education Coordinator
NC Baptist Hospital, Winston-Salem

Margaret "Peggy" Yarborough, R.Ph., M.S.,CDE, FAPP
Pharmacist Clinician and Director
Diabetes Outcomes Management Program
Wilson Community Health Center

3:00–6:00pm **Registration**

5:00–6:00pm **NCPhA Awards Session**

6:00–7:00pm **Reception Honoring Award Recipients**

7:00pm **Opening Banquet**

Charles M. West, P.D.
Executive Vice President, NARD
Keynote Speaker

FRIDAY, MAY 19, 1995

7:30am **TMA Foundation Breakfast**

7:30am **Christian Pharmacists' Breakfast**

7:30am **UNC Alumni Assn. Breakfast** honoring
John T. Henley, Distinguished Service Award recipient

8:00am **Registration Desk Opens**

8:30am–12:30pm **1st General Session**
••2 hrs. ACPE #188-088-95-009••
"While I'm Doing Pharmaceutical Care, What's My Computer Supposed to be Doing?"
Bill G. Felkey, M.S.
Asst. Professor of Pharmacy Care Systems
Auburn Univ. School of Pharmacy
Auburn, AL

Open Mike Session
Installation of NCPhA Officers

9:00am–3:30pm **WA Artisan Tour** *(buses load at 8:45am)*

10:00–11:00am **TMA Business Meeting**

Noon–4:00pm **Exhibits and Apron Luncheon**

2:00–3:00pm **NC PharmPAC Meeting**

3:00pm **NC Board of Pharmacy Public Hearing**

6:00pm **Hoedown at Taylor Ranch** *(buses leave at 6pm)*
featuring a "Country Bash Dinner Buffet," Country Band, Clogging, Square Dancing, Country Line Dancing and Instruction, and more!

SATURDAY, MAY 20, 1995

7:00am	**WA Walk-A-Thon**
7:30am	**Kappa Psi Breakfast**
8:00am	**Registration Desk Opens**
8:30am	**WA Coffee**
8:30am–12:30pm	**2nd General Session** **••2 hrs. ACPE #188-088-95-010••** **"Homeopathy and Herbal Medicine"** June H. McDermott, M.S., M.B.A. Clinical Assistant Professor UNC School of Pharmacy, Chapel Hill Michael V. Rogers, Pharm.D. Dr. Rogers OTC Homeopathic Medicines
9:00am–5:00pm	**Board of Pharmacy Exam Review**
9:30–11:00am	**Woman's Auxiliary Business Session**
12:30–2:30pm	**WA Luncheon—TBA** Entertainment by Jean Fowler, *Soprano* "Salute to Rodgers and Hammerstein" **WA Installation of Officers**
Afternoon	**Golf Tournament**
Afternoon	**Tennis Tournament**
1:00–3:00pm	**"Financial Strategies for the 90's" (no CE)** Lydia F. Woody, CFP, District Manager American Express Financial Advisors Chapel Hill
1:00–3:00pm	**Workshop "Drug Induced Disease"** **••2 hrs. ACPE #188-088-95-011••** Molly A. Scott, Pharm.D. Asst. Professor of Pharmacy Practice Campbell Univ. School of Pharmacy

3:00–5:00pm **Workshop "Leadership Training for Young Pharmacists"**
••2 hrs. ACPE #188-088-95-012••
Jim Morrison
President, The Company
Overland Park, KS

7:00–9:00pm **Phi Delta Chi Reception**

9:00pm–midnight **TMA Dance featuring "Coastline Band"**

SUNDAY, MAY 21, 1995

9:00am–noon **3rd General Session**
••2 hrs. ACPE #188-088-95-013••
"New Drugs"
T. Donald Marsh, Pharm.D., Director
Mountain AHEC, Asheville
"New Uses for Old Drugs"
Wesley G. Byerly, Pharm.D.
Director, Drug Information Services
NC Baptist Hospital, Winston-Salem
Program Evaluation & Adjournment

Convention Hotel and Registration Information

Convention and hotel registration information was mailed to all NCPhA members in early March. If you plan to attend and have not received your convention registration material call the NCPhA office at 800-852-7343 and information will be forwarded to you immediately.

A block of rooms has been reserved for this meeting at the Grove Park Inn. We anticipate the hotel filling quickly and encourage you to make your hotel reservation(s) by phone. Rooms may be reserved by calling the Grove Park Inn reservation office at (704) 252-2711 or 800-438-5800.

The California Pharmacists Association Educational Foundation and the Iowa Pharmacy Foundation are pleased to present. . .

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August 28 thru September 4, 1995

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Who Should Attend:
Pharmacists in all practice settings interested in evaluating new prescription drugs, increasing their knowledge of drug-related problems in dent and improving their patient counseling skills in order to increase compliance.

New Prescription Drugs: Breakthroughs or Just Me-Toos?
5 hours CE, ACPE No. 181-113-95-015

Part I: New Cardiovascular Drugs
Part II: New Central Nervous System Drugs
Part III: New Anti-Infective Agents

Objectives:
At the conclusion of this three-part program, the participant should be able to:
- explain the pharmacological profile and mechanism of action of the new drug;
- recommend an appropriate dosing regimen for the new drug.

Controversial Issues in Dental Pharmacotherapy
2 hours CE, ACPE No. 181-113-95-016

Objectives:
After attending this program, the participant should be able to:
- explain the rationale for antibiotic premedication of patients at risk from oral bacteremia;
- select the most effective non-narcotic agents for control of dental pain based on patient and drug-specific selection criteria;

The California Pharmacists Association and the Educational Foundation are approved by the American Council on Pharmaceutical Education as providers of continuing pharmaceutical education.

Pharmacist Patient Consultation Program: Counselling to Enhance Compliance
3 hours CE, ACPE No. 181-113-95-017

Objectives:
Upon completion of this program, the participant will be able to:
- recognize subjective evidence of noncompliance based on patient responses to "prime questions" and "show and tell;"
- eliminate problems that may result in compliance problems.

Faculty:
Karen A. Baker, MS, RP
Associate Professor
University of Iowa
Colleges of Dentistry a
Pharmacy
Iowa City, IA

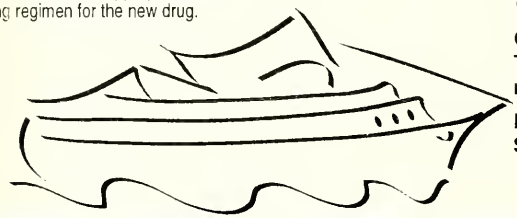
William D. Baker, RPh
Clinical Instructor
University of Iowa
College of Pharmacy
Iowa City, IA

Karla Silver, RPh
Supervisor, Outpatient
Pharmacy
UCLA Medical Center

Your state association will benefit from your registration. Please identify your state affiliatio when registering.

Cruise and seminar registration are separate. To receive a brochure or for additional CE registration, contact CPhA at (916)444-7812 x33

For cruise information contact Special Event Cruises at (800)326-0373.



Cruise to Alaska

ITINERARY:

Day		Port	Arrive	Depart
Monday	August 28	Vancouver (Canada Place)		5:30pm
Tuesday	August 29	Cruise the Inside Passage		
Wednesday	August 30	Juneau	1:00pm	11:00pm
Thursday	August 31	Skagway	7:00am	5:00pm
		Haines	6:30pm	11:00pm
Friday	September 1	Cruise Glacier Bay	6:00am	3:00pm
Saturday	September 2	Ketchikan	8:00am	3:00pm
		Cruise Misty Fjords	5:00pm	8:00pm
Sunday	September 3	Cruise the Inside Passage		
Monday	September 4	Vancouver (Canada Place)	7:00am	

BOARD OF PHARMACY EXAM REVIEW

The Grove Park Inn
Asheville, North Carolina
Saturday, May 20, 1995

PROGRAM

9:00–9:05 a.m.	**Introduction of Program** Ronald W. Maddox, Pharm.D., Dean Campbell University School of Pharmacy
9:05–10:10 a.m.	**NC Pharmacy Law Review** David Work, R.Ph., J.D., Executive Director North Carolina Board of Pharmacy
10:10–10:30 a.m.	**Refreshment Break** Breaks sponsored jointly by Campbell University and UNC School of Pharmacy
10:30–11:45 a.m.	**Review of Parenteral Antibiotics** Byron May, Pharm.D. Campbell University School of Pharmacy Duke University Medical Center
11:45–1:00 p.m.	**Luncheon**
1:00–1:15 p.m.	**NC Pharmacy Format** Al Lockamy, R.Ph., President North Carolina Board of Pharmacy
1:15–2:10 p.m.	**Pharmacokinetics Review** Ronnie Chapman, Pharm.D. Pfizer Clinical Coordinator
2:10–2:30 p.m.	**Refreshment Break**
2:30–3:15 p.m.	**Review of Over-the-Counter Products** Stephen M. Caiola, M.S., R.Ph. UNC School of Pharmacy
3:15–4:30 p.m.	**Errors and Omissions: Compounding** Robert L. Smith, M.S., R.Ph. UNC School of Pharmacy
4:30–4:45 p.m.	**Program Evaluation**



PHARMACISTS. TAKE TWO MINUTES AND CALL THE AIR FORCE IN THE MORNING.

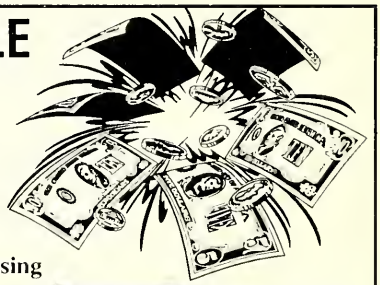
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1995 PHARMACY LEADERS FORUM SUMMARY OF DISCUSSION FEBRUARY 17–19, 1995

The meeting was chaired by the President of the North Carolina Board of Pharmacy. Discussions took place pursuant to the agenda attached. The following notes are a general description of activity at that meeting.

The first item on the agenda included reports from both schools of pharmacy. Dean Bill Campbell from UNC proceeded to describe recent faculty activities. These included the Chinese equivalent of the Nobel Prize for Dr. Lee and Dr. Brian Rittenhouse's organization of an international conference to be held in Chapel Hill in April.

Dean Campbell went on to describe the school's efforts in the external Pharm.D. development and funding. It was noted that letters from various association presidents would be helpful in support of this activity. He also noted that the renovation of Beard Hall will soon be in progress, as will plans for building expansion which have some priority in the university at this time.

The student representative, Brandon Maddox, presented a report on their yearly activities.

Dean Ron Maddox from Campbell University delivered his report which included an observation that pre-pharmacy is the number one major at Campbell University. He noted that they have a new degree program in pharmaceutical sciences which will direct graduates into industry or graduate school. He reported that his neighbors include several politicians in the State House, one potential senator and a congressman.

Dr. Swanson described new faculty efforts and the drug information residency at Campbell. Joe Whitehead commented on their communications course and the success of a student who won the National Patient Counseling competition last year.

Laura McArthur and Laura Isley reported on student activities. Ross Brickley noted that Todd King had expressed interest in a student chapter at Campbell University for consultant pharmacists.

Legislative activities discussed were many and varied. Bill Post, Bob Crocker, Mike James, Benny Ridout, Steve Bullock, Larry Long, Phil Crouch, Joe Whitehead, Ross Brickley and the attorney for the Retail Pharmacists Association, George Hearne, all participated in this discussion. Several references were made to "niche" pharmacy in what appeared to be both a positive and negative sense. On this day, February 18, 1995, Mr. Jim McAllister predicted that he was "not going to be in the drug distribution business in two years, certainly not in five years."

The Board of Pharmacy report was delivered by David Work, who stated that the Board had changed its procedure for disciplinary actions, holding pre-hearing conferences whenever possible. A case is presented to a member of the Board, who then makes a recommendation to the full Board after hearing all the facts in the case. This avoids the necessity of long disciplinary hearings, which have been more and more prevalent, delaying action in many cases. He also reviewed the Board's patient counseling and recent disciplinary actions.

He reviewed several rules which are scheduled for a proposal in the near future, with a public hearing, probably in April, and an anticipated effective date of July 1, 1995. He reviewed the election, which will be held in the spring of this year, of a member of the Board to serve a term beginning in 1996. He noted that Bill Randall and Margaret Carpenter have submitted petitions for this position. A general review was made of the workload study which was proposed by the North Carolina Board and adopted by the National Association of Boards of Pharmacy. Dr. Work reported that the Executive Com-

mittee of the Association had approved funding for a research project that will be presented by NABP by May of 1996.

Bill Randall, Chairman of the Committee to Revise the Practice Act, reported on their activities. He noted that several meetings had already been held and more were planned for the future, with a target date for legislation in 1997. It may be possible to get certain specific pieces of legislation in front of the General Assembly for the '95 session, if all can agree and it appears that the activity can be accomplished cleanly.

Dean Ron Maddox reported on the efforts of his committee to develop a statement on health care reform. Much discussion ensued. After a thorough review of all issues, it was moved by Dean Maddox, and seconded by Betty Dennis, to adopt the position statement and the motion passed unanimously. Dr. Larry Swanson offered to send copies of the statement to other associations, legislators and other specific individuals.

Dean Bill Campbell presented a synopsis report of the task force assigned last year to review the status of pharmacy technicians. He asked David Work to describe his experience with a television interview on WTVD-11. David Work played a video of the three segments of the interview, which were telecast on Channel 11 in Durham on February 6, 7, and 8th. He reported that the reaction of pharmacy technicians was quite vocal and it is clear that this issue needs resolution through legislation. He proposed that there be a statutory change to provide for a definition of pharmacy technician as a person participating in the dispensing of a prescription under the supervision of a pharmacist, as noted in the statute, required annual technician registration with the Board of Pharmacy and a payment of a fee, leaving qualifications as to training and testing up to standards adopted by the Board.

Ross Brickley had asked that the matter of certification of consultant pharmacists be on the agenda, noting it was his desire to take this issue to the Committee to Revise the Practice Act at a later date.

Joe Whitehead reported on his Very Involved Pharmacists (VIP) project with pharmacists as speakers and materials provided by Glaxo and/or NARD. He felt the results were good considering the nature of pharmacists today. A suggestion was offered to approach Rotary and other such clubs to air this kind of presentation.

A discussion of a proposed public relations campaign was held and it was noted that this would cost between twenty and fifty thousand dollars. No one volunteered to fund this effort.

A vigorous and conflict-filled discussion about Medicaid activities occured, involving many participants. Benny Ridout talked at length, noting that he believes prospective DUR does save money, while participation in HMO's does not. One comment made by another participant was that a captivated network was not a wise course of action, noting that the Florida program has produced disastrous results. The proposed HMO for services in the Charlotte area could run into some problems, as the EDS contract has about 18 months to go, and this could result in litigation. A comment was made that the pharmacy network has done about all it can do under the circumstances. It was noted that the network was doing about two million dollars worth of business per month in forty-eight states and we should have pride in their accomplishment. One participant noted that the result was "now all on Benny" at which point John Mitchener fell off his chair.

Ross Brickley commented briefly on the six-prescription limit for Medicaid beneficiaries, noting that the average nationwide in long term care facilities is 8.3 per month. This subject obviously needs attention.

Managed care was adequately covered in other sections of the meeting.

It was the consensus of the group that health care reform as a public issue is gone. Private care reform is a roller coaster issue, however. It's clear that we need relationships with physicians, hospitals and other groups. One popular phrase is "market

driven health care reform." It was suggested that we refer to the position statement developed by Dean Maddox on this subject.

Two items were added to the discussion at the end of the meeting—TENNCARE and a report from the Department of Health Services from Charles Reed. John Nance reported that his company, TENNCARE, produced 1,100 and 900 interventions at their two facilities in Tennessee within forty-five days. An intervention in this case was a change in an order to conform to formulary requirements.

Charles Reed reported on recent issues at the Division of Health Services, including a publication on health statistics, and the North Carolina Medical Society's publication on smoking and health. He also had positive things to say about the Helix program sponsored by Glaxo. The meeting concluded at 11:15 a.m. on February 19, 1995.

Attention: Pharmacists



Have your patients' medicines had a check-up?

Many of your patients take several different medicines every day. Separately each one works well. But if they take two or more different medicines in combination without checking with you to be sure they work safely together, they can sometimes be harmful...even dangerous.

The next time you counsel about medicines, be sure to ask:

"What other prescription and nonprescription medicines are you taking?"

A public service message from the National Council on Patient Information and Education (NCPIE) and the U.S. Administration on Aging

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RATIONAL THERAPY SERIES NOW AVAILABLE

The Institute for Contemporary Pharmacy Research, Inc. (ICPR) has introduced the Rational Therapy continuing education series. The series is designed to assist pharmacists, physicians, and allied health professionals in providing appropriate therapy for disease-state management. Utilization of the information included in the series enables the provision of optimal pharmaceutical care while controlling costs.

Each component in the series is accredited by both the University of Massachusetts Medical Center (ACCME) and the Massachusetts College of Pharmacy (ACPE) and funded through an unrestricted educational grant. Participants completing this program will receive two (2) contact hours (0.2 CEUs).

Rational Therapy: Acid Peptic Disease is now available. The series includes a monograph, an audio cassette, a computer learning disk, and a slide presentation. *Rational Therapy: Asthma Disease* will soon be released

Future programs will focus on Diabetes, Depression, Hypertension, Migraines and more!

If you would like to receive more information on this program you may call the NCPhA office at 800-852-7343 or make your request in writing to: NCPhA, P.O. Box 151, Chapel Hill, NC 27514.



The Becton Dickinson and Company, "Customers for Life" pharmacy support program, featuring a pharmacist toll-free 800 number for prompt access to information about B-D products and diabetes care services, continues to expand rapidly.

"The complimentary B-D Customers for Life program has grown 25% in the past year, with over 20,000 pharmacists now participating," said Janice Cannizzo, Becton Dickinson Director of Market Planning.

"Answering patient questions quickly is a central ingredient in helping pharmacists build stronger, long-term relationships with their diabetes care patients," Ms. Cannizzo added. "We have also developed a number of free services pharmacists like."

Some of these value-added services are:

- An "I Have Diabetes" wallet card, customized at no cost with the participating pharmacy name and telephone number. Pharmacists have given away more than 1.1 million of the popular cards to their patients.
- 250,000 B-D Blood Glucose Testing Diaries have been given away free to patients by participating pharmacies.
- Over 50,000 B-D Continuing Education Booklets have been distributed to member pharmacists during the past two years. These complimentary CEU booklets cover timely topics such as "Intensive Insulin Therapy" and "Counseling Patients with Diabetes."

As the B-D Customers for Life program moves into its third year, new materials are in development that will help pharmacists satisfy growing patient interest in new advances in diabetes care due to the outcomes of Diabetes Control and Complications Trials (DCCT).

In you would like more information about enrolling in B-D Customers for Life, please call 1-800-423-2346 (Monday through Friday 9am–5pm EST).

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ACQUISITION COMPLETE—GLAXO INC. AND BURROUGHS WELLCOME LOOK TO FUTURE

Glaxo plc announced that it had completed its acquisition of Wellcome plc and will begin immediately the process of combining the strengths of both organizations to create a global, research-based pharmaceutical company well-positioned to meet patients' needs.

The acquisition will lead to synergies between the expertise and activities of Glaxo and Wellcome around the world, including the companies' U.S. units, Glaxo Inc. and Burroughs Wellcome.

"The new company will combine two of the most distinguished names in pharmaceutical research, each with a strong, complementary research base and a significant U.S. presence," said Robert A. Ingram, president and chief executive officer of Glaxo Inc. In addition, a broader therapeutic line and increased commercial strength will enable the new company to continue leading the adaptation to new customer needs. Together they will create the largest company in a highly fragmented U.S. pharmaceutical marketplace, with a total U.S. market share of about 8.1%.

"The combination of Glaxo-Wellcome talents and resources will benefit the new company, but it also will benefit patients who are looking to companies like ours for new medicines for cancer, diabetes and other debilitating conditions," Ingram said. "As we adapt to new marketplace pressures and grow stronger, we can better maintain the financial strength to sustain investments in increasingly expensive research and development. That's important because, in this industry, meeting unmet medical needs will remain the ultimate standard of success."

In the U.S.—where the headquarters of Glaxo Inc. and Burroughs Wellcome are just miles apart in North Carolina's Research Triangle Park—integration teams already at work within Glaxo will expand to include Burroughs Wellcome employees. Teams will be organized around critical functions, and each will be charged with gathering information, comparing the strengths and structures in each organization, analyzing current and future business needs, and making recommendations on how best to meet them. Similar efforts are under way in each country where Glaxo and Wellcome have a presence.

"The combination of Glaxo-Wellcome talents and resources will benefit the new company, but it also will benefit patients who are looking to companies like ours for new medicines for cancer, diabetes and other debilitating conditions."

In short term, during the data-gathering and decision-making stages, Glaxo Inc. and Burroughs Wellcome will each continue their normal operations, largely as separate companies. Until these stages are complete, the new company will not have sufficient information to make specific decisions or take specific actions. While it is not yet known how long the information-gathering phase will continue, the new company's management is committed to completing the integration as quickly as possible.

Ingram said the company would rely on several principles as the integration process moves forward. They include:

- Respect for the strengths of each organization, and the intent to create a mix of skills that will best help the company achieve its future goals.
- Pursuit of strategic synergies and growth opportunities.
- Achieving short-term benefits without jeopardizing long-term goals, and avoiding cost-cutting at the expense of future expense.

• Careful and decisive implementation of integration plans.

The process is expected to uncover overlaps in staffing, he added. While the ultimate effect on staffing levels will not be immediately known, Ingram said that management is committed to the idea that all restructuring decisions will be guided by business needs, and that every employee would be treated with respect, dignity and sensitivity. In addition, a variety of support services will be instituted to aid employees affected by staffing decisions.

Ingram also emphasized the company's continued commitment to maintaining a leadership role in supporting local communities.

"As a stronger company emerges from the integration of Glaxo and Wellcome, we expect to be in a strong position to continue our leadership in community affairs," Ingram added. "Until we learn more about each other, we won't know how the specifics of our community programs may change, but our commitment to partnerships with the people in our communities will be as strong as ever."

In part because of their proximity in central North Carolina, Glaxo Inc. and Burroughs Wellcome have often collaborated on community initiatives. Ingram said the new company would build on that foundation of mutual respect.

"Glaxo and Burroughs Wellcome share a common commitment to drug discovery, and they share common goals," he said. "We look forward to working together to maintain a leading position in our industry, in our communities, and in delivering important medicines to the people who need them."

Late Breaking News

The Glaxo/Burroughs Wellcome merger was approved by the Federal Trade Commission on March 16.



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From the Schools

Campbell University School of Pharmacy

Four of the 22 recipients of NCSHP's Award for Continuing Excellence in 1994 were Campbell faculty members. Peggy Yarborough, Stephen Fuller, Jay Groce and Dan Teat received these awards at the NCSHP Winter Meeting on February 9. This same "quartet" were recipients of these awards last year, as well.

Fifty-eight students from the Class of 1996 visited Eli Lilly & Company in Indianapolis, March 1–3. They were accompanied by faculty members Wendell Combest, Tom Holmes, and Larry Swanson and local Lilly representative Todd Watts and his wife Katie. Surprisingly, this cosmopolitan Buies Creek crowd couldn't seem to find much to do in the evening in the little sleepy town of Indianapolis! Tell me about it...speaking of sleepy...!

Congratulations are in order for Connie Barnes and the staff of our Drug Information Center. The Commission on Credentialing of ASHP granted accreditation to our Drug Information Residency program at its meeting in February. There are only twenty accredited residency programs of this type in the United States This is the first program to achieve this status with the drug information center located outside of a medical center or pharmaceutical company setting.

We had a great visit with Dr. Cal Knowlton, president–elect of APhA. He gave challenging messages to our student body and local preceptors about pharmaceutical care. If you get a chance to speak with Cal, ask him about his rather unpretentious limousine arrival in the center of Harnett county!! He ain't never seen anything like that down here!!

Submitted by Larry Swanson, Professor and Chairman, Department of Pharmacy Practice, Campbell University.



Saudi Arabia Pharmacy Leader Visits Campbell University School of Pharmacy (CU). From left, Dr. Antoine Al-Achi, assistant professor of pharmaceutics, CU; Karl Kappeler, assistant director of pharmacy, Duke University Medical Center (DUMC); Bashar Horanieh, (DUMC); Moammed Hassan Altoukhi, pharmacy resident, DUMC; Sulaiman Al Salamah, director of pharmacy of the King Faisal Specialist Hospital and Research Center (KFSHRC), Riyadh, Saudi Arabia; Adel Saud Al-Humaidan, pharmacy resident, DUMC; Joe Whitehead, Raleigh, special assistant to the dean, CU; Abdullah S. Alhumardan, pharmacist, KFSHRC; Sana R. Sukkari, drug information specialist, KFSHRC; Dr. Ronald Maddox, Dean, CU; Dr. Thomas Holmes, Associate Dean, CU; Dr. Larry Swanson, chairman of pharmaceutical sciences, CU.

UNC School of Pharmacy

The biggest news coming out of the UNC School of Pharmacy is that "teaching is still job 1." This message was conveyed by Dr. Boka Hadzija, Professor of Pharmaceutics, who won her third Tanner Award for Excellence in Inspirational Teaching, given by Chancellor Paul Hardin.

Dr. Hadzija's long list of teaching awards began with her first Tanner award in 1975. A second followed in 1988 to accompany ten other awards received over a twenty year period. Dr. Hadzija was educated in Croatia and came from London to join the UNC faculty in 1971.

"Receiving this award means that I am accepted by my students both in the classroom and outside. Nothing else matters, including research and grants. I keep up with many of the students I have made contact with here when they return to the Chapel Hill area on trips. That means a lot because it suggests that I have had some impact on their lives, and that is the greatest satisfaction you can have as an educator."

Bill Campbell, Dean of the School of Pharmacy, was elected to a five-year term as Trustee of the United States Pharmacopia (USP) at the 175th anniversary meeting held March 9–12 in Washington, D.C. Dr. Campbell was elected as a representative of the pharmaceutical sciences, with an emphasis on pharmaceutical outcomes research. In commenting on his selection, Dean Campbell noted, "USP is becoming a major factor in the practice of pharmacy through development of drug information standards and products, such as the USP-Drug Information (USP-DI), used by pharmacists in all health care environments. With the recent alliance between USP and the American Medical Association to explore merging USP-DI with AMA-Drug Evaluations (AMA-DE), the USP can become a major 'change agent' in fostering cooperation between physicians and pharmacists in improving pharmaceutical care."

Submitted by Kevin Almond, Assistant Dean, UNC School of Pharmacy Chapel Hill.



Pharmacy Foundation of NC 1994–95 Board of Directors. *Left to right*, Pam Joyner, Bill Wilson, Barney Paul Woodard, Jim Matthews, Joe Whitehead, Bob Hall, Joe Westmoreland, Milton Whaley, Teamie West, Jimmy Creech, Ed Fuller, Ann Spencer, Henry Smith, Linda Butler, Lisa Grimes, John Hood, Dean William Campbell, and Laura Burnham.

AROUND THE STATE

Garner—Tom Jones Discount Drug Center was recently recognized by Drug Topics as one of the nation's "Independent Superstars." The pharmacy was named a superstar in the category of Exceptional Merchandising, Advertising and Promotions.

Blowing Rock—Pharmacist/artist **Joe Miller** was recently honored with a reception by the Watauga County Arts Council. The Council recognized Wautuga's own for his many contributions to the arts. Joe is the owner of Boone Drug Company, where he has been practicing pharmacy for the past 25 years.

Winston–Salem—**LeAnne Kennedy** was recently elected a new pratitioner of the Academy of Pharmacy Practice and Management by the American Pharmaceutical Association. LeAnne is a staff pharmacist at NC Baptist Hospital in Winston-Salem.

Fayetteville—**Rebecca Chater**, pharmacist and store manager of Kerr Drugs in Cliffdale Plaza recently won the company's President's Circle Award. Managers receive the award for gains in teamwork, employee development, profit improvement, and expense and security control.

Hickory—**Tad Adams** and **Bill Mixon**, pharmacists at Catawba Memorial Hospital, recently achieved the status of certified diabetes educators. The certification exam is sponsored by the National Certification Board for Diabetes Educators and requires 2,000 hours of experience in direct diabetes patient education and successful completion of a comprehensive exam which measures an individual's knowledge of diabetes education and care.

Albemarle—Jim Davis Drug Co. was elected by the nation's drug wholesalers to the Drug Topics Honor Roll of Outstanding Independent Drugstore Retailers. Owner **Jim Davis** attributes much of the store's success to the jewelry department he installed two years ago.

Burnsville—**Charles Gillespie** and Pollard's Drug Store were recently named recipients of the first ever Business Citizenship Award, presented by the Yancey County Chamber of Commerce.The award recognizes notable citizenship, business leadership, and community service.

WEDDINGS

Jane Wyatt wed Michael Maney on November 26 in Mars Hill. Jane is a 1994 graduate of the UNC School of Pharmacy.

Christy Combs and **Bradley Weaver** were married on October 29 in McLeansville. Bradley, a graduate of the UNC School of Pharmacy, is employed by Kerr Drugs.

Susan Suddreth wed Michael Baker on November 26 in Ronda. Susan, a graduate of the UNC School of Pharmacy, is employed by Elk Pharmacy Inc.

Gianna Funderburk and Derek Bryan were married on November 26 in Richlands. Gianna is a graduate of Campbell University School of Pharmacy and is employed by Neil Medical Pharmacy in Mooresville.

Polly Johnson wed Michael Lauffenburger on November 25 in Conway. Polly received her B.S. degree in '94 from the UNC School of Pharmacy, where she is currently pursuing a doctorate in pharmacy. Polly is employed with Kaiser Permanente in Durham.

Karen Killen and Tracy Bans were married on November 5 in Knightdale. Karen, a UNC School of Pharmacy graduate, is employed by Kerr Drugs in Clayton.

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REPORT OF THE NCPHA ELECTIONS COMMITTEE

The NCPhA Elections Committee met on March 22, 1995, at the Institute of Pharmacy in Chapel Hill, to open, tally, and record the ballots cast in the 1995 mail election. The results are:

FOR PRESIDENT ELECT

Phillip Crouch, Asheville

FOR MEMBER OF THE EXECUTIVE COMMITTEE

(two-year terms)

Randy Ball, Wake Forest
Frank Burton, Greensboro
Peggy Yarborough, Sims

Elected officials will be installed in their respective offices during an installation session held at the 1995 NCPhA Annual Convention in Asheville.

Members of the Elections Committee are Mel Chambers, LeRoy Worley, Frances Gualtieri, and William Wells.

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CORRESPONDENCE COURSE

PATIENT COUNSELING: POISON IVY, OAK, AND SUMAC PART I: OVERCOMING THE MYTHS



Thomas A. Gossel, R.Ph., Ph.D.
Professor of Pharmacology and Toxicology
Ohio Northern University
Ada, Ohio



J. Richard Wuest, R.Ph., Pharm.D.
Professor of Clinical Pharmacy
University of Cincinnati
Cincinnati, Ohio

Goals

The goals of this lesson are to identify common myths about poison ivy, oak and sumac, review the sensitization process, and discuss the major symptoms of contact dermatitis caused by these plants.

Objectives

At the conclusion of this lesson, participants should be able to:

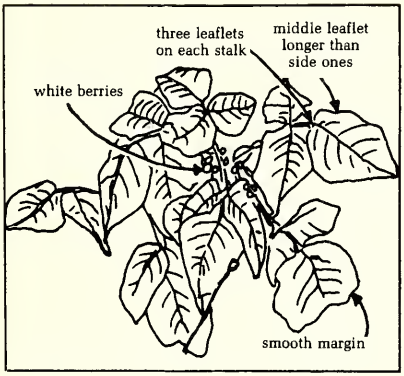
1. identify the active constituent of poison ivy that causes lesions to erupt;
2. select the major symptoms caused by contact with poison ivy, oak or sumac;
3. exhibit an understanding of how to respond to myths associated with sensitization to poison ivy, oak or sumac plants;
4. demonstrate knowledge of the sensitization process caused by contact with poison ivy, oak or sumac plants; and,
5. choose from a list, information to convey to patients who ask about poison ivy, oak or sumac reactions.

Up to 75 percent of Americans reportedly are sensitive to poison ivy, oak and/or sumac. At the same time, many people cannot recognize these plants. Victims of skin lesions caused by these plants often seek the assistance of a pharmacist before, or in lieu of, a physician. It is the goal of this lesson to assist in providing advice to these individuals.

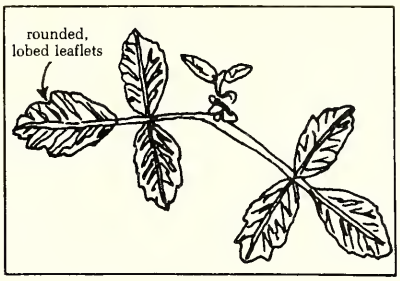
The Myths

There are strong beliefs about poison ivy, oak and sumac contact. Some are accurate, while others are not.

Myth #1: Everyone recognizes Poison Ivy, Oak and Sumac. These common three-leaf arrangements of poison ivy and oak plants may be their only consistent characteristic. There are individuals, including those who spend prolonged periods of time outdoors, who sill have trouble recognizing the plants. One reason is that the plants can assume a wide variety of sizes, shapes and colors, depending on where they are growing. Figures 1 and 2 are line drawings of the three plants which may aid in their recognition. Unfortunately, the plants are hardy and grow in adverse conditions of soil, water,



(A)



(B)

Figure 1
Poison ivy (A) and poison oak (B) leaves.

and sun, creating difficult, but not impossible, eradication problems.

Poison ivy, the most common source of exposure, usually grows as a woody vine attached to trees, rocks, fences, or other objects. It may grow along the ground as a creeping vine. Free-standing shrubs and bushes exceeding six feet in height have also been reported.

The pointed and oval-shaped leaves grow on a stalk usually three to four inches long. In spring and summer they are green.

During dry spells, late summer, and on into autumn, they change coloration to various shades of yellow, red or brown.

When flowers are present, they are arranged in loose, irregular clusters at the axis of the leaves with white-to-green coloration. Grayish-colored, waxy fruits with vertical grooves are sometimes present. These fruits may remain attached throughout the winter.

There are two major varieties of poison oak. Eastern poison oak is an erect, perennial plant that normally grows as a low, woody shrub which does not climb. It is found along sandy areas, or in the dry soils of oak or pine groves.

Western poison oak grows as an upright shrub with numerous stems emerging from the ground. It may appear as a vine on a tree, telephone pole or clinging to other vines.

Like the poison ivy plant, poison oak leaves grow in three-leaflet clusters. However, they are irregularly lobed and more closely resemble oak tree leaves. The plants have white-to-green flowers which may or may not mature into flattened, berry-like fruits. These may also remain on the plant throughout the winter.

The shape and color of poison oak leaves can vary depending on where the plants grow and the time of year. Leaves are narrow and thin in extremely shady areas. In full sunlight, they are thick and glossy. Alongside dusty roads, they are normally dull and lusterless.

The leaves of poison sumac resemble neither poison ivy nor poison oak. The seven-to 13-leaflet clusters are arranged in pairs, with a single leaflet projecting from the middle. Poison sumac generally grows as a tall woody shrub, or coarse small tree.

One factor that prevents many people from recognizing these plants is that they do not all grow universally throughout the country. Poison ivy is found in nearly every part of the U.S., with the exception of Nevada and California. Eastern poison oak grows within a large triangular area bounded by New Jersey, Texas and Florida. Western Poison oak is found along the west coast

from southern Canada to Mexico.

Poison sumac is confined mostly to areas east of the Mississippi River. It grows preferentially in swampy, moist, boggy areas.

Therefore, it is possible that an individual who has never traveled outside the West may not have seen either poison ivy or poison sumac. Or, an individual from a metropolitan or large urban area, who rarely visits the countryside, may not have seen any of these plants at different periods in their development. They cannot associate any particular feature with the potential to cause dermatitis.

Each plant does have one factor in common. They all contain the same active allergen, an oleoresin complex called urushiol. As a group, poison ivy, oak and sumac are the most common causes of plant-induced dermatitis in the United States.

Poison sumac is the least common cause of plant-induced poisoning of the group, owing in large part to where it is found—generally confined to uninhabited areas. Thus, the remainder of this lesson is concerned mostly with poison ivy and poison oak.

Myth #2: Poison Ivy/Oak is a Problem Only in the Summer. A quick explanation of how these plants cause rash should dispel this myth. Urushiol is distributed throughout all parts of the plant except the flowers, pollen and epidermis. This occurs through a canal system located within the plant structure. Touching an uninjured plant or merely rubbing against it will not cause a rash. When the plant is injured, urushiol is released. As little as one microgram can initiate a rash affecting all sensitized areas of the body of a susceptible person.

Certainly the danger of urushiol poisoning is greatest in the early spring and summer when the plants' sap flow is highest. Another danger almost as great exists in the early fall, when leaves are dry and fragile. Also, even though the plant is inactive during the winter months, it is still alive and urushiol is present. Parts of the plant that have been cut away from the base or dug out to the ground still contain urushiol, even though they are dead.

A problem can occur in the winter with people who cut or handle firewood. It doesn't matter how recently the wood was cut before bringing it into the home, or if it had been cut and stacked for awhile. Either way, if poison ivy vines growing on it are injured and touched even months after the plant injury, dermatitis can occur.

Myth #3: There Must be Direct Contact with the Plant Before a Reaction Can be Produced. A patient may believe that he has suffered from poison ivy dermatitis without ever coming into contact with an actual plant. What is often unrecognized is that urushiol may be transmitted on clothing or shoes, garden tools, sporting equipment, and animal fur. It may have been picked up on a pair of shoes. When the shoes are worn, the victim is resensitized and the dermatitis reaction occurs. Another scenario is that the family pet may have picked up urushiol while rummaging through the woods. Later, as its owner pats the animal, the allergen is transferred and the dermatitis occurs.

Time will slowly reduce the allergic quality of the causative oleoresin on clothing and other inanimate items. Washing the items in hot, soapy water, or dry cleaning, if appropriate, is the best way to remove the danger

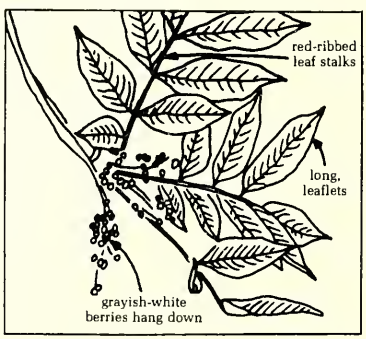


Figure 2
Poison sumac leaves.

of subsequent contamination. Rubber or plastic gloves should be worn while handling and washing the pet.

Myth #4: Dermatitis Rash Can be Prevented by Washing After Exposure. This myth has some truth to it. If urushiol is removed from the area with soap and water within 5 to 10 minutes of exposure, a reaction may be aborted, except in highly sensitive persons. Washing does remove urushiol from the skin before it can be absorbed, but it must be done as soon as possible after contact with the allergen.

A study was undertaken to look specifically at the concept. People who were slightly sensitive, and others who were highly sensitive, to urushiol, were included. Injured leaves were applied directly to their forearms. Washing within 30 minutes prevented the reaction in some, but not all of the less sensitive individuals. Washing at 60 minutes was totally ineffective in all cases, regardless of the degree of sensitivity.

Urushiol penetrates the skin rapidly. Once this happens, it attaches to skin protein to form the allergen. This sets off the allergic response. A few minutes after exposure, it cannot be removed, even with the strongest surgical soap.

Myth #5: Some People are Naturally Immune to Poison Ivy Dermatitis. Though it is a well known fact that there are people who have never experienced a poison ivy reaction, and these individuals believe they are immune, the concept is a myth. Actually they have never been sensitized in the first place. It is true that an individual's immune system may be more or less reactive compared to another person's, and thus responds to antigenic challenge at different rates. Some people are highly susceptible to antigenic challenge and others are only weakly susceptible.

Development of the Allergic Reaction. Urushiol contains a mixture of four chemicals, all of which are sensitizers. Urushiol is called a hapten because, by itself, it is not allergenic. Instead, it must first combine with protein from within the body to form antigens. When it contaminates the skin, urushiol binds to skin proteins to begin antigen production. Specific cells produced in the lymphatic system collect in the area and transport these antigens to the reticuloendothelial system. There, antibodies are formed which are then carried back through the vascular system where they are deposited ("fixed") under the skin.

The first time an individual comes in contact with urushiol, this reaction is initiated. Each subsequent contact adds to the total quantity of antibodies produced. The initial contact may occur without the individual's knowledge. The degree or extent of each dermatologic response is dependent on prior sensitization, which may have occurred weeks or even years before, and on the quantity of antibodies formed.

Once sensitized and when sufficient antibodies are present under the skin, the individual may experience poison ivy dermatitis reactions every time he comes into contact with urushiol, for the rest of his life. As with other immune processes, the extent of reactivity normally recedes with advancing age. Additionally, some individuals who experience an especially severe reaction early in life are less sensitive thereafter. This may be due to a process similar to hyposensitization, which is discussed in Part II of this series.

Occurrence. As was mentioned earlier, it is estimated that as many as 75 percent of all Americans are sensitive to poison ivy. Occurrence is correlated to age, as depicted in Figure 3. Infants and very young children are rarely affected. Sensitivity must be acquired from exposure. Also, the reticuloendothelial system of small children is not sufficiently functional to produce antibodies. This system develops with age.

After an initial surge during the teens when outdoor activities are highest, the incidence of dermatologic reactions seems to decline between age 20 to 40. Perhaps the increase in incidence of reactions observed during the 40s and 50s is due to spending more time in the yard or with the grandchildren. Then, as we age, the reticuloendothelial system becomes less

responsive to sensitization. Antibodies which were formed years before are less reactive. With advancing years, many people are exposed to the cause less frequently.

Myth #6: Poison Ivy is Contagious and Spread by Blister Exudate. Of all the misconceptions about poison ivy/oak, this is one of the most common. The myth is perpetrated because a rash frequently appears initially on one area of the body; then, perhaps days later, it may appear on another. Or, streaking of the rash appears after scratching an area. The person interprets this secondary reaction as a response to having spread the disorder by scratching the original rash and contaminating the other sites with blister exudate.

The exudate from blisters of poison ivy/oak lesions does not spread the rash. This fluid is serum that collects in response to an allergen-IgE-mediated inflammatory reaction occurring beneath it. There is no urushiol present in this exudate. In face, experiments have demonstrated that when the liquid from blisters of one individual is placed on the skin of another sensitized individual, the second person will not develop the rash in response to that application.

The reason a rash appears at a secondary site later is because various areas of the body have differing levels of reactions to the allergen. The same reasoning holds for the "streaking" response. Streaking occurs because this is the pattern in which the specific antibody that is formed in response to antigen stimulation becomes fixed to the skin. However, the concentration varies in different areas of the body.

A sensitized individual who comes into contact with the allergen will most likely experience the first symptom to rash at or near the site of original contact the caused the initial sensitization, regardless of where the urushiol was actually absorbed. With time, as other sites (those having lesser concentration of antibody) become activated by interaction with circulating antigen, they also develop the typical rash. So the appearance of the delayed response is independent of scratching the initial rash, or contamination of one part of the body with blister exudate from another.

Symptoms of Poison Ivy Reactions

Symptoms appear within 12 to 24 hours of the first exposure to urushiol. In some persons, symptoms may require three days to appear. Localized itching due to irritation of nerve endings in the epidermis usually occurs first. Soon after this first sign, patches of redness and inflammation, then warmth,

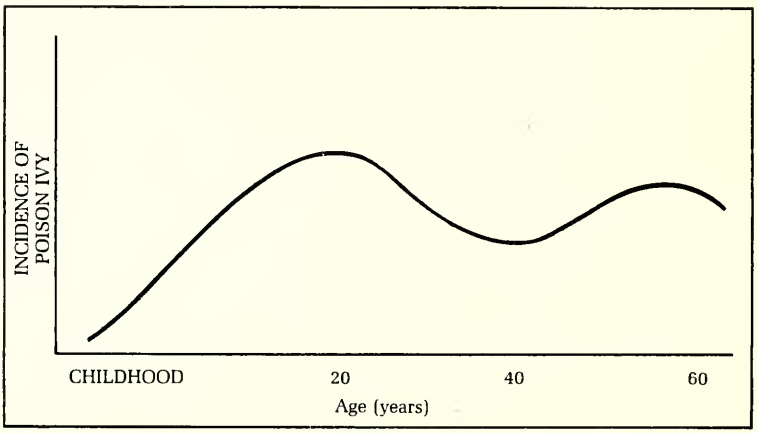


Figure 3
Incidence of poison ivy expressed by the individual's age.

and finally, blisters appear. The blisters can rupture, ooze, and crust after a few days. Tender, thin skin is involved more commonly than hairy areas. Most cases heal without permanent damage.

If itching is not relieved and the victim scratches vigorously enough to break the skin's integrity, infection may follow. On occasion, severely affected individuals develop complications including blood dyscrasias, kidney damage, occasional psychotic reactions, dyshidrosis (disturbance in sweat production or excretion) and skin pigmentation changes.

Summary

This ends the first of two parts of the review on poison ivy/oak and its treatment. In part II, the treatment with OTC products, and advice to convey to affected persons will be discussed.

A professional development program made possible by an educational grant from

SEARLE

CONTINUING EDUCATION QUIZ

Patient Counseling: Poison Ivy, Oak, and Sumac Part I: Overcoming the Myths

1. Of the following characteristics, which is the only in that is common between poison ivy and poison oak?
 a. Both grow solely as climbing vines.
 b. Both change color from green to red in early summer.
 c. Both grow in nearly every part of the country.
 d. Both have a three-leaf arrangement

2. All of the following statements about urushiol are true EXCEPT:
 a. it is found in poison but not poison oak.
 b. it is released when the plant is injured.
 c. it is an oleoresin.
 d. it is a sensitizing agent.

3. Urushiol is contained in which of the following parts of the poison ivy plant?
 a. Epidermal layer
 b. Leaf canals
 c. Flower
 d. Pollen

4. A chemical such as urushiol that, by itself, is not the allergen is called a (an):
 a. reacten.
 b. antigen.
 c. hapten.
 d. antibody.

5. Based on the information presented on the development of the allergic reaction to poison ivy, which of the following body systems is LEAST involved in the process?
 a. Lymphatic
 b. Pulmonary
 c. Reticuloendothelial
 d. Vascular

6. The type of poisonous plant that has flowers arranged in loose, irregular clusters at the axis of its leaves, and grayish-colored, waxy fruits is:
 a. poison ivy.
 b. poison oak.
 c. poison sumac.

7. The type of poisonous plant that contains 7-13 leaflet clusters with a single leaf projection from the middle is:

a. poison ivy.
b. poison oak.
c. poison sumac.

8. Which of the following is a true statement?

a. As little as 1 mcg of urushiol can initiate a dermatitis reaction.

b. Once the poison ivy plant has died, it cannot cause dermatitis.

c. Poison ivy is only a problem in the summer.

d. Touching an uninjured plant will cause a rash.

9. The initial itching of poison ivy dermatitis is caused by:

a. reactions with keratin precursor cells.

b. migration of lymphocytes to the area of exposure.

c. simulation of melanocytes in the subdermal area.

d. irritation of nerve endings in the epidermis.

10. Which of the following is a true statement?

a. Dermatitis rash can be prevented by washing the exposed area even if it is eight hours later.

b. Some people are naturally immune to poison ivy and will not experience a reaction.

c. There must be direct contact with the poison ivy plant before a reaction can occur.

d. Urushiol penetrates the skin rapidly and attaches to skin protein to form the allergen.

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Please circle correct answer

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2. a b c d	5. a b c d	8. a b c d
3. a b c d	6. a b c	9. a b c d
		10. a b c d

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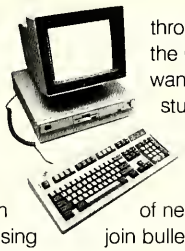
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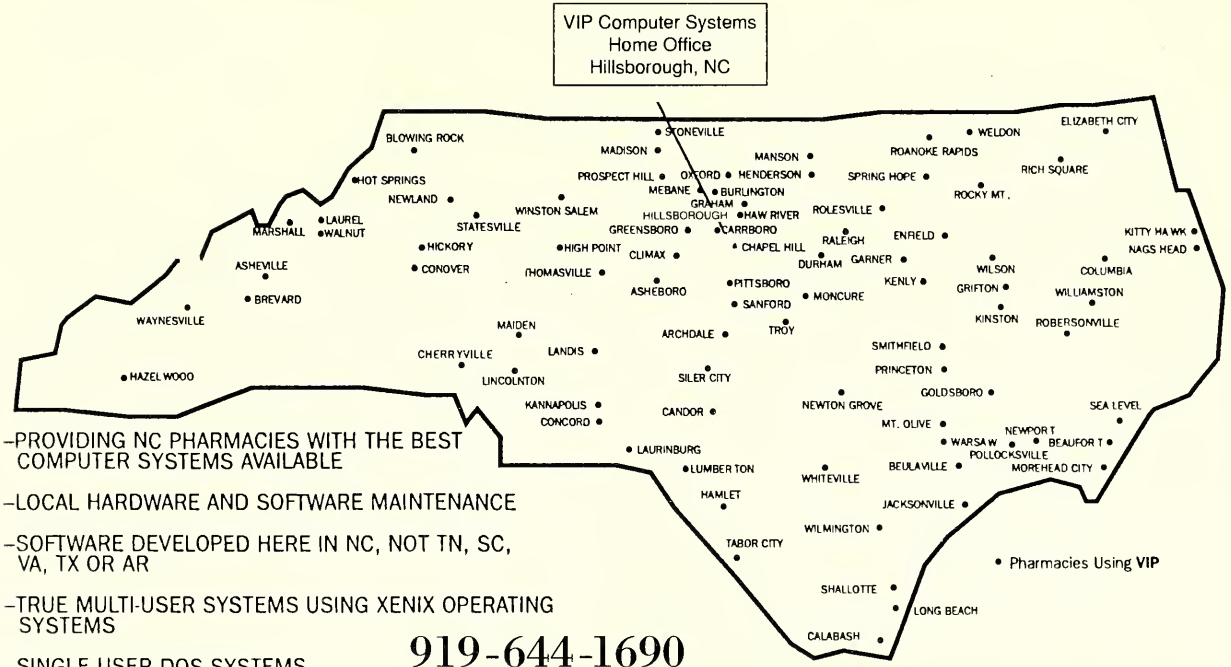
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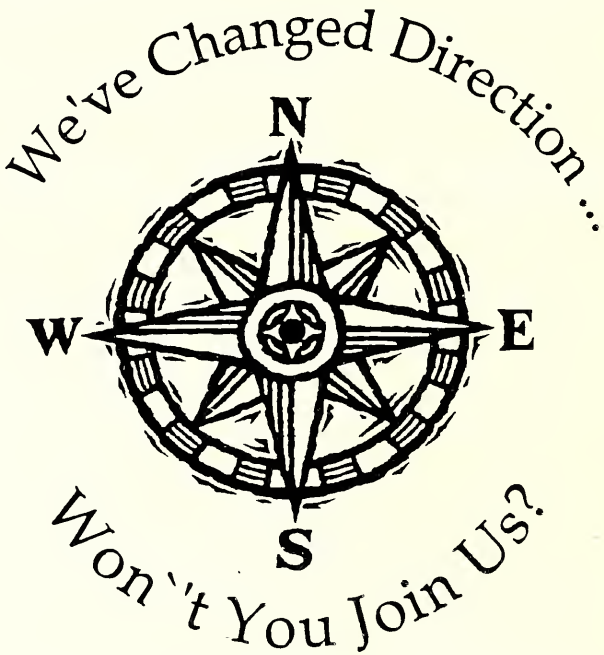
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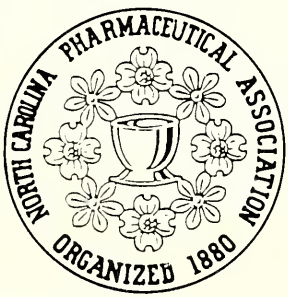
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CAROLINA
JOURNAL OF PHARMACY

(USPS 091-280)

July/August 1995 **Volume 75** **Number 4**

ISSN 0528-1725

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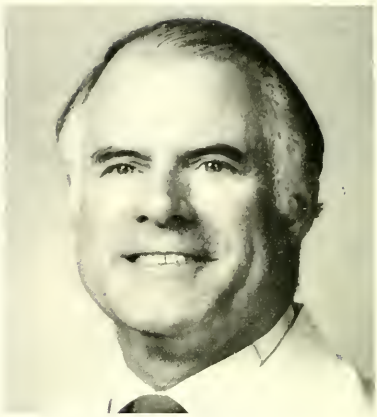
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The Carolina Journal of Pharmacy is published bi-monthly by the North Carolina Pharmaceutical Association, P.O. Box 151, Chapel Hill, NC 27514. *The Journal* is provided to NCPhA members through allocation of annual dues. Subscription rate to non-pharmacists is $25.00 (continental U.S.). Overseas rates on request. Second class postage paid at Chapel Hill, NC.

WATT'S UP

PRESIDENT'S MESSAGE

"A UNIFIED VOICE FOR PHARMACY IN NORTH CAROLINA"



Mickey Watts
NCPhA 1995-96 President

Can we all agree that the one constant in pharmacy today is rapid, constant change? Do you feel unable to direct or control any of the changes that are occurring? If all segments of pharmacy were united, would we be better prepared to deal with the future?

We can discuss pharmaceutical care, patient outcomes and assessments, disease state management, discriminatory pricing, patient counseling, and all the other "hot-topics" of change indefinitely. But if we are to be effective in protecting our future, and the future of our patients, pharmacy must speak with one voice. We must realize that whatever affects one division of pharmacy has the potential to affect all of pharmacy and all pharmacists. We must unite, meet regularly to resolve our differences and present a unified front to those who view pharmacy as a commodity and not a profession.

By uniting and speaking with one voice, we can receive much fairer treatment from third party payers, drug manufacturers and others. Think of the strength we would have if hospital pharmacists, consulting pharmacists, retail pharmacists (both chain and independent), and pharmacists in academia could put aside our egos, forget past differences and work together. If we can focus on the expansion of our profession and those patients we are committed to serve, we can act as one. Our job is to take care of those who are sick, while surviving in the marketplace and earning a living.

One change that will impact us all is requiring the Doctor of Pharmacy degree as the entry level degree into the profession. If this is going to happen—and many of our leaders and decision makers are telling us that it will—let's unite and make this change exciting and achievable by every pharmacist who wants it. We must help develop an external Pharm.D. program that is affordable in time *and* dollars, and has value for today and into the future. We can help insure that unnecessary obstacles to earning this degree are avoided and we must encourage participation by every pharmacist who can benefit from this additional degree and education.

North Carolina has an excellent system of continuing education for health professions through the Area Health Education Centers. Program coordinators and facilities are available in every part of our state. If the 5,700 B.S. pharmacists and the 450 Pharm.D. pharmacists were united, we could help insure adequate funding and cooperation between the AHEC and the academic community to support an external Pharm.D. program.

Uniting pharmacy and all its practitioners to achieve the greatest financial and political impact would be an accomplishment of historic proportions.

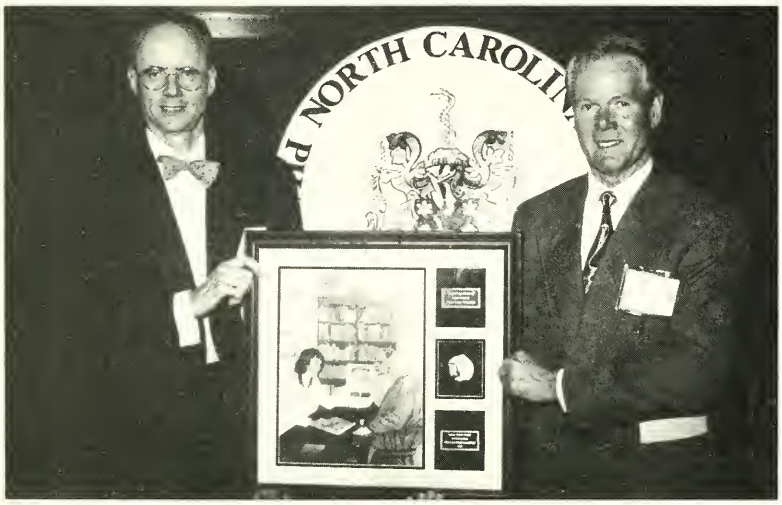
One voice to accomplish this is NCPhA.

NC PHARMPAC

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Julian Harris receives the DuPont Pharma "Innovative Pharmacy Practice" Award from Roy Rhoden of DuPont. Photo by Qualex



ANNUAL CONVENTION OF THE NCPHA AND AFFILIATED AUXILIARIES GROVE PARK INN, ASHEVILLE, N.C. MAY 18–21, 1995

REPORT OF THE OUTGOING PRESIDENT

Joseph A. Edwards, Jr.

THE FOUNDATION FOR THE FUTURE

Every successful association is built on a solid foundation consisting of a clear strategic plan, progressive constitution and policies, strong direction and support from its committees, innovative membership development, and a dynamic and enthusiastic leadership that is able to combine these component parts into a cohesive action plan. This administration has committed itself to reinventing the mission and purpose of the North Carolina Pharmaceutical Association. Each part was carefully examined. What we have created is a more efficient, more focused, and more productive association.

We began the year with a weekend devoted to developing a comprehensive NCPhA Strategic Plan. Facilitated expertly by Dean Ron Maddox, the Executive Committee produced a list of ten strategic objectives which became the basis for all of the work accomplished this year and will be the guide for work in the future.

Our Membership Committee, chaired by Randy Ball and advised by Rebecca Chater, worked tirelessly to develop a Membership Strategic Plan, entitled Project 3000. It is the structure for our upcoming membership drive and our ongoing plan for meeting the professional needs of our members. To identify these criteria, the Membership Committee surveyed pharmacists in our state, both members and non-members, and over 500 surveys were returned. The committee, along with association staff, then developed a demographic profile of our members. All of these efforts are part of a strategy for making NCPhA more account-able to its members and for increasing our membership to 3000.

No committee has spent more time and effort this year than the Finance Committee under the capable leadership of Betty Dennis Every aspect of association finances was reviewed, critiqued, and streamlined. Now we have a clear picture of both income and expenditures. With this information, we have developed a fiscally responsible budget for 1995. The committee also has developed a tracking system to monitor our finances on a regular basis. I especially want to thank Bill Inman,the association's auditor, for his valuable contributions to the Fin-ance Committee.

This year the Pharmaceutical Care and Compensation Committee came into its own.

This was the year that the Pharmaceutical Care and Compensation Committee came into its own.The committee is a joint effort of NCPhA and NCSHP, and is one more example of how effectively the two associations are working together. The committee looked at many innovative practice options, supple-mental software programs, implementation strategies, and avenues of compensation for pharmacy

services. It has produced an Action Plan for Pharmaceutical Care Practice which will be the groundwork for expansion of pharmacy advancement. My thanks go to Julian Harris and Jean Douglas of NCSHP for their many hours dedicated to this effort.

The buzz words of today are "pharmaceutical care." The message was delivered by a most ambitious new approach to continuing education. Never has the membership of NCPhA been exposed to so many valuable programs. From the Pharmacy Practice Seminars in Wilmington to the Socio-Economic Seminar in Greensboro, from the Asthma Workshop in the Research Triangle to the acclaimed Passport to the Future: Models of Pharmaceutical Care in Greensboro, the Continuing Education Committee has become the fore front of pharmacy education. No amount of recognition is sufficient for June McDermott's valued leadership in chairing this committee. Furthermore, June did a wonderful job in coordinating Pharmacy Week in North Carolina.

1994-95 was the year that the **V**ery **I**nvolved **P**harmacists program hit the road. The Public and Professional Relations Committee has presented the VIP program to over twenty local pharmacy associations in the state, and hundreds of pharmacists have benefited from the lessons in public communication. Accolades go to Joe Whitehead and Jeff Peterson for all of their time, travels, and enthusiastic presentations.

The Ethics, Grievance and Practice Committee dedicated itself to truly being the judicial arm NCPhA. After developing guidelines for membership, the committee began a program of enforcing the Association's Code of Professional Ethics. Thanks to Joe Re and Tom Thutt for leading the way.

Some of the hardest and most time consuming work fell on the shoulders of Steve Caiola and the Constitution and Bylaws Committee. We now have a completed Constitution to present to this Convention. In addition, much work has gone into the rewrite of the By-Laws. Although the committee did not reach completion on this part of its charge, the finished document should be ready for action by the 1996 NCPhA Convention.

What a year it has been with Health Care Reform in America. During all of the chaos, our association was there, working diligently to make pharmacy's voice heard. Of the thirteen NC Health Care Reform Committees, NCPhA members were represented on four and pharmacy's direct voice was present on four more. A number of meetings were held with Dr. Jim Jones, Executive Director of the NC Health Planning Commission. Thanks go to Kevin Layne who took on this enormous task as chairman of Health Reform and Health Policy Committee. A very special recognition goes out to Dean Maddox who chaired the NC Pharmacy Health Care Reform Position Statement Task Force. Through his guidance, we now have a progressive and dynamic document which outlines pharmacy's commitment to quality health care in America. When times got tough, we were there fighting for the integrity and expansion of pharmacy practice.

Nowhere in North Carolina were times any tougher than in the NC General Assembly. The election of 1994 has dramatically changed the structure and leadership of the Legislature. This session saw the NCPhA fighting on many fronts. No one pharmacist in North Carolina has done as much for pharmacy as Mike James, chairman of the State Legislative Committee. As a registered lobbyist and champion for pharmacy legislation, Mike has spent more than 200 hours in the NC General Assembly fighting for our cause. Our association's lobbyist, Virgil McBride, helped us greatly in our efforts. I must take this time to thank the Academy of Retail Pharmacy for putting together an effective political action network. Under the leadership of Bill Post and Bob Crocker and the lobbying team of Bill Rustin and George Hearn, pharmacy's voice was heard and respected. We are confident that we shall be successful in our legislative agenda. We will not stop until our goals are accomplished. A very successful Pharmacy

Day in the NC Legislature was held in February as a kickoff to our legislative efforts. My thanks go to the students and professors from Campbell University School of Pharmacy and UNC School of Pharmacy who attended and made valuable contributions. These students are the leaders we need to blaze the trail to a prosperous future for pharmacy.

No accomplishment this year has been more personally rewarding than helping create the Committee to Revise the Pharmacy Practice Act. Bill Randall is doing a great job in leading this group and results are already being realized. Thanks also to Dave Work who supported and championed our efforts to move forward in our demands for the expansion of pharmacy practice. We are honored to have Mike James and Pam Joyner represent NCPhA at these meetings. I especially want to thank Tim Ives, who has been my mentor and who jump-started the efforts to form this committee.

I also wish to acknowledge the accomplishments of our other committees: Editorial Advisory Board, chaired by Connie Fleming, which has produced a new look and energy for the NC Journal of Pharmacy; the Employer/Employee Relations Committee chaired by John Setzer; the Consolidated Student Loan Fund ably managed by Joe Johnson; the Museum Committee under the leadership of Milton Whaley, which is progressing in its efforts to create a permanent pharmacy display; and all of the other members who gave their time and efforts in strengthening our association.

There are many, many others who need recognition. Thanks to Al Mebane, Betsy and the professional staff for putting in the time and effort to make our association a model for other states to follow. Special thanks go to Erie Cocolas who is retiring after this Convention and who has been the anchor of our staff for many years. She will be sorely missed. Thanks to all members of the Executive Committee who have remained strong and powerful in the face of controversy as well as accomplishment. There is no doubt that our Executive Committee has taken control of our association and is committed to pharmacy progress and service to its members. Thanks to Past-President Rob Bizzell for making the transition of administration so smooth. Thanks to Peggy Jackson and the Woman's Auxiliary of the NCPhA for all of their support and especially for the wonderful contribution of window treatments and carpet for the Institute of Pharmacy. Thanks to Charlie Black and the Traveling Members' Auxiliary for their valuable contributions. Thanks to Ross Brickley, Larry Long, Bill McDonald and all the members of the Academy of Consultant Pharmacists who have worked for unity and pharmacy strength. Thanks to Dan Garrett, Don Marsh, Frances Gualtieri, and Fred Eckel of NCSHP for many joint-efforts and behind-the-screens strategy sessions. Thanks to Dean Bill Campbell and Dean Ron Maddox for personally contributing to NCPhA and for enrolling their students in the process of developing a strong professional organization. Thanks to the pharmaceutical companies, pharmacy wholesalers, and program sponsors who support us in education, programs and delivery of pharmaceutical care. Most of all thanks to my wife, Kathy, and daughters, Allison and Anna, who have been pillars of support, encouragement, enthusiasm and love. I love you and I pledge my time to you in the coming years for the pursuit of your dreams and commitments. Finally, I thank all of you for allowing me to serve as your President. I have had a unique opportunity to travel throughout the state and nation and meet many pharmacists who let their actions speak their passion and commitment.

Our NCPhA team has completed its mission for success during this administration. I proudly turn over the gavel to Mickey Watts and wish him the very best as he leads us in the coming year. I leave you with one last message which I presented at the UNC School of Pharmacy Commencement, "We must develop a vision of what we want pharmacy to look like and then design as action plan to make it happen." I am honored to have played a part in the journey.

NCPHA OFFICERS AND EXECUTIVE COMMITTEE
Association year 1995–1996

Officers

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P. O. Box 39
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Work # 704-252-7636

Joseph A. Edwards Jr. Past President
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Work # 919-833-7558

W. Robert Bizzell, Past President
Realo Drug Store, Onc.
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Work # 919-527-6929

Alfred H. Mebane III, Executive Director
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Work # 800-852-7343

Executive Committee

John A. Mitchener III
Member at Large, 1996
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Member at Large, 1996
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Work # 704-333-2167

Thomas R. Thutt
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Randy Gray Ball
Member at Large, 1997
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Work # 919-556-1900

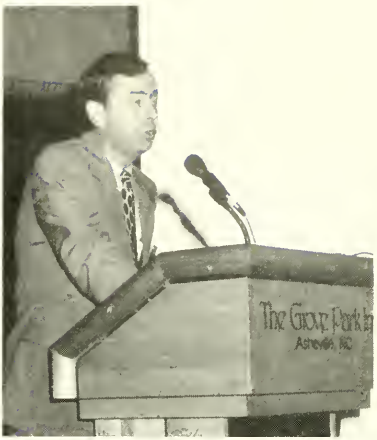
F. Michael James
Member at Large, 1996
702 N. Person Street
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Work # 919-832-6432

Frank Burton
Member at Large, 1997
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Greensboro, N.C. 27408
Work # 919-727-7130

Michael Overman
Member at Large, 1996
Lord's Drug Store
915 Merrimon Avenue
Asheville, N.C. 28804
Work # 704-252-7626

Peggy Yarborough
Member at Large, 1997
6845 Flat Rock Road
Sims, N.C. 27880
Work # 800-334-4111

Convention Highlights '95



Campbell University had a very good year.



You mean I'll be president next year!



Not everybody was thrilled about the Convention.



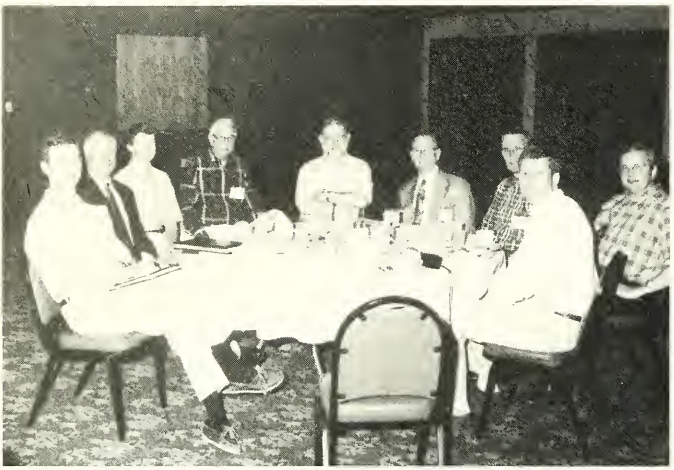
June and Homeopathy, an excellent program

Photos by Qualex.



Tennis in the mountains. A good time was had by all.

The Carolina Alumni Breakfast. Growing in popularity each year.





What are they looking at?

ANNUAL REPORT TO THE CONVENTION OF THE CONSOLIDATED PHARMACY LOAN FUND COMMITTEE

The Consolidated Pharmacy Loan Fund Committee met March 5, 1995 at the Institute of Pharmacy in Chapel Hill to discuss issues relative to the loans made to students in the pharmacy schools at both Campbell University and the University of North Carolina at Chapel Hill.

Sixty-eight loans of $300.00 each were made in 1994. Seventeen loans were made to Campbell students and fifty-one were made to UNC students. In the spring of 1995, twenty-nine loans of $300.00 each have been made—nine to Campbell students and twenty to UNC students. Outstanding loans as of December 31, 1994 totaled $130,340.32. These loans are made based on the needs of the students at UNC-CH and Campbell University Schools of Pharmacy. No interest is charged as long as the loans are paid as agreed after the student leaves school. The maximum amount a student can borrow is $300.00 per semester and $1800.00 over three years. Delinquent accounts, which are minimal, are charged interest at 2% over prime rate if payments are not made in the minimum amount of $50.00 per month within six months after leaving school. The limit on the amount of the loans appears to still be adequate and there are no plans to raise it at this time. Contributions to the Fund in 1994 amounted to $11,592.87.

The following recommendations were made:

1. A letter should be sent to all the people who have established a loan fund with less than $300.00, asking them to either contribute enough money to meet the $300.00 minimum or let the money in their fund be put into the Undesignated Fund.

 If there is no response from the mailing, the money in that fund will be rolled into the Undesignated Fund. Each fund must have $300.00 in order for a loan to be made from that fund.

2. A paragraph requesting contri-butions for the Student Loan fund will be included in the annual mailing for Association membership dues and also included in the second mailing that goes out in June from the Pharmaceutical Association.

3. A letter will be sent from the Pharmaceutical Association to the County and regional Pharmaceutical Associations requesting contributions for the Loan Fund.

Several notes and letters have been received this past year from students who have benefited from the loans. These loans are greatly appreciated by the students and the committee would like to encourage everyone to consider making a contribution. It is a very worthwhile cause that makes it possible for these students to pay some of their educational expenses.

MEDICAID REMINDER

The Enrollment Section of the N.C. Medicaid Program urges all providers to notify them of any changes if they are enrolled in the Medicaid Program. These changes would include IRS number, store name, address, ownership, lease or management.

If any of these changes occur, it is imperative that you notify the N.C. Department of Human Services, DMA, P.O. Box 29529, Raleigh N.C. 27626-0529. This must be brought to the attention of Enrollment.

From: Mary J. Williford, R.Ph.
Pharmacy Review Section Chief

ANNUAL REPORT TO THE CONVENTION OF THE NCPHA NOMINATING COMMITTEE

In accordance with Article 1, Sections 1, 2, and 3 of the NCPhA Bylaws, the Nominating Committee submits the following slate of candidates subject to the January 1996 mail ballot. Each candidate has expressed a willingness to serve if elected. Candidates may be nominated from the floor of the Convention if the nomination is accompanied by a brief, written biographical sketch and and assurance from the candidate that he or she will serve the particular office if elected.

Candidates who receive a plurality of the vostes cast will be installed in their respective offices at the 1996 Annual Convention in Greensboro.

For the office of President Elect
Laura M. Vance, Winston Salem
Jimmy S. Jackson, Garner
Pamela U. Joyner, Morrisville (*nominated from the floor*)

For the Office of Executive Committee Member-at-Large
(Three to be elected, each for a two–year term)
Linda L. Butler, Chapel Hill
Debra Smith, Charlotte
Stephen C. Dedrick, Durham
Joe R. Whitehead, Raleigh
Kevin L. Almond, Chapel Hill
Larry S. Long, Summerfield
nominated from the floor
Gary Glisson, Nashville
Kevin R. Layne, Eden
Mark A. Manship, Lenoir



M. Rankin Caruthers, Burlington, with his wife and displaying his Fifty + Certificate, as the newest member of the NCPhA Fifty + Club.
Photo by Qualex

WOMAN'S AUXILIARY OF THE NCPHA OFFICERS
Association year 1995–1996

President–**Daphne Ashworth**, Cary
First Vice President–**Jewel Oxendine**, Charlotte
Second Vice President–**Jean Morse**, Raleigh
Recording Secretary–**Neta Whaley**, Durham
Corresponding Secretary–**Margaret Cekada**, Mount Olive
Historian–**Shirley Barricks**, Greensboro
Parliamentarian–**Betty Overman**, Asheville
Advisor–**Peggy Jackson**, Garner
Advisor–**Tracey Smith**, Farmville
Coordinator–**Betsy Mebane**, Chapel Hill



Daphne receives the president's pin from the outgoing president, Peggy Jackson



Neta and Vivia examine the table decorations at the Ladies Luncheon.



Left to right: **Rebecca Work, Tracey Smith, Jean Morse, Shirley Barricks, Daphne Ashworth, Jewel Oxendine, Peggy Jackson, Betty Overman, Neta Whaley, and Betsy Mebane.** Photo by Qualex

WOMAN'S AUXILIARY OF THE NORTH CAROLINA PHARMACEUTICAL ASSOCIATION

REPORT OF THE CONVENTION

The 68th Annual Convention of the Woman's Auxiliary of the North Carolina Pharmaceutical Association met May 18-21 at the Grove Park Inn in Asheville. What a glorious time of year to be in our beautiful mountains.

Prior to the Opening Banquet, a reception was held honoring the NCPhA Award Recipients.

Charles M. West, PD, Executive Vice President of NARD was the keynote speaker at the Opening Banquet. He spoke before many familiar faces as many NCPhA members are also members of NARD.

David R. Work of Chapel Hill was named Pharmacist of the Year. Congratulations to David for a well–deserved honor.

Friday morning, the Woman's Auxiliary loaded buses and visited several local artisans, including potters, glass blowers and the Penland School of Art. A delicious lunch was served at the Cedar Crest Restaurant in Spruce Pine.

Friday evening we joined NCPhA members, boarded buses and headed for Taylor Ranch for a Hoedown with great country music and a delicious barbecue buffet. We all had a chance to learn some line dances and later try them out.

Bright and early on Saturday morning we had our Annual Walk-A-Thon. Kendall Drug Company, a division of Bindley Western, graciously sponsored our T-shirts again. Afterwards, our Coffee was held in the hospitality suite. Our thanks to Daphne Ashworth and her committee for providing the wonderful "goodies."

The Woman's Auxiliary Annual Business Meeting was held at the Grove Park Inn with approximately 42 members present. Along with various reports, we had a visit from Katy, the Kangaroo, who is used with the association's program entitled "Katy's Kids." The program teaches youg children appropriate and responsible medication use. The auxiliary purchased the costume for the association.

After door prizes were given out, we boarded buses and went to the Woodfield Inn in Flat Rock for our luncheon. Betty Overman and other members of the Western NC Pharmaceutical Auxiliary had made beautiful table arrangements. Special entertainment was provided by Jean Fowler of Hendersonville, who sang selections from Rogers and Hammerstein. Vivia Creech installed our officers for 1995-96.

Special gifts of jewelry and a scrapbook were presented to Erie Cocolas marking her retirement from the staff of the NCPhA. Although we will miss Erie at the Institute, we look forward to seeing her at the Woman's Auxiliary functions. Many thanks to all the auxiliary members for the lovely silver tray presented to me for my year as president.

The TMA sponsored the annual TMA Dance on Saturday night with the Coastland Band performing. At intermission the raffle drawing was held with many great prizes given away. Edith Edmonds of Greensboro was our lucky auxiliary member. She won the $500.00! Faye Welsh and her committee made this event most successful. A great time was had by all who attended. Thanks TMA members for the annual dance!

I do want to thank the Executive Board, all committees, Betsy, Erie, and the NCPhA staff for such cooperation and hard work. We couldn't do it without you. This has been a rewarding year for me as president. Thanks to all of you for your support through the year.

God bless.

Peggy Jackson
President, Woman's Auxiliary
1994-1995



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Interventi

"Contact your local Lilly represen
for a copy of this pharmacy cont
education monograph." (MG-

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TRAVELING MEMBERS' AUXILIARY OF THE NCPHA OFFICERS
Association year 1995–1996

President–Randy Eckerd
P.O. Box 11124
Hickory, NC 28603
(Ciba-Geneva Pharmaceuticals)

First Vice President–Jay Massey
P.O. Box 4011
Durham, NC 277
(N.C. Mutual Wholesale Drug Company)

Second Vice President–Donnie Thomas
4325 Millpoint Rd.
Greensboro, NC 27406
(Ciba-Geneva Pharmaceuticals)

Secretary Treasurer–Raymond James
5304 Birch Pl.
Raleigh, NC 27609
(Qualex-Retired)

TMA FOUNDATION OFFICERS

Charles Black, Forest, VA: 5-year Term
Raymond W. James, Raleigh: 4-year Term
W. V. O'Quinn, Durham: 3-year Term
Junior Little, Royster, GA: 2-year Term
Dick Hoffman, Asheville: 1-year Term



Left to right: **Randy Eckerd, Donnie Thomas, Jay Massey and Raymond James.**



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AIR FORCE

ANNUAL REPORT OF THE PUBLIC AND PROFESSIONAL RELATIONS COMMITTEE

The primary focus of the committee this year has been on the Very Involved Pharmacist (VIP) program. This is a speaker's assistance program designed to train our members to give public presentations and provide speaker assistance kits for the presentations scheduled.

Our approach has been through the Local Pharmaceutical Associations. Mr. Jeff Peterson has conducted speaker training sessions with about one third of the local associations. The presentation includes information on VIP kits available from NCPhA. Over two dozen presentations to local audiences have resulted.

A letter was sent to all Rotary Clubs in the state making them aware of the availability of speakers and programs through their local pharmacists. A letter was also sent to local association presidents urging them to schedule a speaker training session if they had not done so. Future plans include informing other civic clubs and professional groups about these programs available through their local pharmacists.

While these results are not dramatic, it is expected that next year's committee will build upon what has been accomplished.

The other activity this year was to assist NCSHP with plans for Pharmacy Week.

Respectfully submitted,
Joe Whitehead, Chairman

REPORT TO THE CONVENTION

Campbell University School of Pharmacy
by
Ronald W. Maddox, Pharm.D.
Professor and Dean

The faculty of the School of Pharmacy consists of thirty-four highly qualified individuals, and the student body is made up of approximately three hundred highly motivated individuals. Dr. Kristen Jones is our only faculty addition this year. Dr. Jones' expertise is pharmacokinetics and her practice site will be the VA Hospital - Durham. The School continues to receive tremendous volunteer support from a cadre of two-hundred and seventy volunteer and adjunct faculty members who serve as preceptors in community, institutional, and industry training sites.

Our faculty continues to be very productive in teaching, scholarly pursuits, and professional service. They have published numerous articles in state and national journals, and submitted grant proposals to state, federal, and private agencies. An example of our productivity is that four of the 22 recipients of the North Carolina Society of Hospital Pharmacists' Award for Continuing Excel-lence were Campbell faculty members for 1994. Peggy Yarborough, Stephen Fuller, Jay Groce, and Dan Teat received these awards at the North Carolina Society of Hospital Pharmacists Winter Meeting on February 9, 1995. Also, it is noteworthy that Dean Maddox received the 1995 American College of Apothecaries Outstanding Service to Community Pharmacy Practice Award.

Congratulations are in order to Dr. Connie Barnes and the staff in our Drug Information Center. The Commission on Credentialing of the American Society of Hospital Pharmacists granted accreditation to our Drug Information Residency program at its meeting in February. There are only 20 accredited residency programs of this type in the nation and this was the first program to receive such status with the drug information center being located outside of a medical center or pharmaceutical company setting.

Students have been involved in a wide-range of professional activities. During the spring break, twenty-eight students attended the American Pharmaceutical Association Annual Meeting in Orlando, Florida. At that meeting Craig Fogle, a fourth-year student, was recognized as the Rhone-Poulenc Rorer and Drug Topic National Scholarship Winner. The scholarship consist of a $10,000 savings bond.

Campbell University is launching a bachelor of science program with a pharmaceutical science major in the fall of 1995. It is felt that graduates of this program will be equipped for a variety of career opportunities as well as having a sound springboard for graduate study in pharmaceutical and other sciences. We believe the primary beneficiary of this pool of talent will be the pharmaceutical industry.

A survey of pharmaceutical manufacturers and research institutions in our immediate area convinced us that the need for this new program is significant. Our survey also found that Campbell University is well located geographically to serve the needs of the pharmaceutical industry and governmental science institutions in the eastern United States.

This has been another exciting and productive year in the history of the Campbell University School of Pharmacy. I take this opportunity to thank you for your assistance and support, which contributes greatly to our success.

REPORT TO THE CONVENTION OF THE 1925 ERA PHARMACY MUSEUM COMMITTEE

The Pharmacy Museum Committee of the North Carolina Pharmaceutical Association held its annual meeting Thursday, October 6, 1994, at the North Carolina Museum of History in Raleigh.

We had a total of thirty (30) in attendance including President and Mrs. Joey Edwards, Executive Director and Mrs. Al Mebane, and museum staff members Jackson Marshall, Assistant Administrator; Pat Phillips, Chief Curator and Adam Newton, Curatoral Specialist.

After a sandwich and dessert lunch, Milton Whaley, General Chairman, welcomed everyone and expressed appreciation for their attendance and for their work on our project. A moment of silent prayer was held in memory of deceased member, Herman Lynch.

The Chairman introduced the museum staff. Jackson Marshall, Assistant Administrator gave us an update and progress report on the installation of the drug store exhibit. The preliminary plans are entitled Health and Healing. This exhibit would be along a chronological time line beginning with the native American Indian, the eighteenth century apothecary, study of health systems within the state, with the light or focal point being the 1925 era Drug Store, with follow up after that of post 1945 technological medicine and modern pharmaceuticals. The space for the entire Health and Healing Exhibit will be approximately 4500 square feet and the Drug Store will be approximately 1200 square feet.

Adam Newton, Curatoral Specialist, has been working with inventory and identification of pharmacy artifacts for the past six months. He stated that we now have in excess of 12,000 items in the collection including a complete set of drug store fixtures.

The next meeting of the committee is scheduled for the fall of 1995. The committee will continue to work to achieve our goal of the installation of the 1925 Era Drug Store in the North Carolina Museum of History.

Respectfully submitted,
Lloyd M. Whaley
General Chairman

The space for the entire Health and Healing Exhibit will be approximately 4500 square feet and the Drug Store will be approximately 1200 square feet.

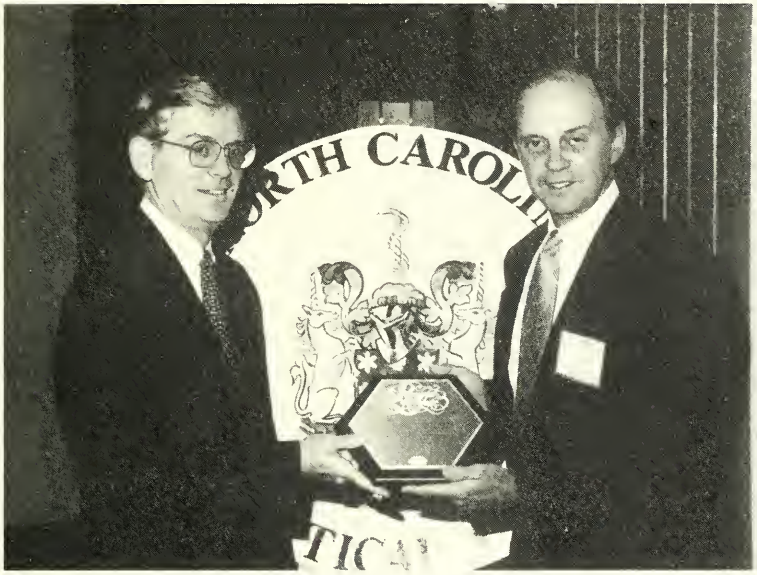
DUQUESNE UNIVERSITY SCHOOL OF PHARMACY CHANGES NAME

Generic drug manufacturer Mylan Laboratories, the nation's largest independent generic manufacturer, has committed a large grant to Duquesne's School of Pharmacy. The new Mylan School of Pharmacy in Pittsburgh will be the only pharmacy school in the nation to be named for a corporate company.

The grant will be used for new labs and to develop a partnership with Mylan for education and research, summer internships and continuing education programs for Mylan employees.

Duquesne's pharmacy school is the sixth largest pharmacy school in the country, with an undergraduate and Pharm.D. enrollment of over 900.

ROCHE "PRACTITIONER OF THE YEAR" AWARDS



Larry Swanson, right, presents the Roche "Practitioner of the Year" Award, as selected by Campbell University School of Pharmacy, to Herman Medlin of Dunn. Photo by Qualex



Steve Caiola, right, presents the Roche "Practitioner of the Year" Award as selected by the University of North Carolina School of Pharmacy to Larry Brown of Greensboro. Photo by Qualex



Julienne Kirk is recognized as the Marion Merrell Dow "Distinguished Young Pharmacist of the Year" by Jim Book of MMD.



Whit Moose, NARD Executive Committee member, presents the NARD Leadership Award to NCPhA incoming president Mickey Watts.

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NORTH CAROLINA PHARMACEUTICAL ASSOCIATION

REPORT OF THE CONTINUING EDUCATION COMMITTEE

Charges and Actions:

1. *Study continuing education (CPE) and how pharmacists can maintain and improve competency.*

The Committee discussed the possibility of presenting a resolution to increase the number of hours of required continuing pharmacy education in North Carolina from 10 to 15. Unfortunately, this is a legislated issue and there is little or no supportive evidence to say that pharmacists who participate in more hours of continuing education programming are actually better pharmacists.

Action: Make no recommendations at this time regarding CE hours for reliscenure.

2. *Prepare and conduct a member survey to determine what is needed in continuing education programming.*

Recently a membership survey was distributed to determine members' satisfaction with the services offered by the Association. A partial needs assessment was done with this survey.

Action: The Committee decided to review the information provided by the responses to this survey before determining the necessity of a continuing education needs assessment survey.

3. *Seek and develop programs to promote implementation of pharmaceutical care.*

Action: Pharmaceutical care was stressed in two programs this year:

a. *Passport to the Future! Models of Pharmaceutical Care and Continuity of Care* (April 1–2, 1995) continued to develop the philosophy of pharmaceutical care that has been growing over the last four years and presented models in the nation where pharmaceutical care is being provided. The idea of continuity of care was introduced. Workshops encouraged pharmacists to discuss their innovative practice ideas and to begin networking with other pharmacists within their geographic regions of the state. This program was designed for pharmacists in all practice arenas.

b. 115th Annual Convention of the NCPhA (May 18–21, 1995): *Pharmaceutical Care—Showcase of Activities in North Carolina* presents further activities in pharmaceutical care, but on a state level. Five models from across North Carolina, including those developing continuity of care are presented.

4. *Study and develop a position on certification programs and an external Doctor of Pharmacy (Pharm. D.) program.*

Pam Joyner surveyed randomly selected pharmacists across NC to determine their interest in participating in an extramural Pharm.D. program. The group discussed the Pharm.D. curriculum and implementation of the program and realized that this is a School of Pharmacy issue and not one that can be dealt with or solved by the Association.

Action: Pam Joyner and Betty Dennis were asked to write a resolution to be submitted by this Committee to ask the University of North Carolina at Chapel Hill and Campbell University Schools of Pharmacy to develop extramural Pharm.D. programs.

5. *Review the feasibility of NCPhA seeking accreditation as an ACPE approved provider for continuing pharmacy education.*

Many resources, including financial and personnel are needed to become and maintain accreditation as an approved ACPE provider. The Association has excellent working relationships with both Schools of Pharmacy.

Action: It is in the best interest of the Association to maintain relationships with both Schools of Pharmacy for the provision of ACPE approved continuing education and not to become a separate approved provider.

ANNUAL REPORT OF THE PHARMACEUTICAL CARE AND COMPENSATION COMMITTEE

Overview and Mission

The Pharmaceutical Care and Compensation Committee (PCCC) is a newly organized committee of the North Carolina Pharmaceutical Association. The purpose of this working group is described in our mission statement.

PCCC will promote all pharmacists as direct patient care providers who deliver pharmaceutical care (PC) and promote the patient's well-being through coordination with other health care providers and are compensated for these services.

The committee was formed at the request of Past-President Robert Bizzell. He contacted me in the spring of 1994 and asked that George Peal and I represent the Association on this matter. We were directed to form a group in collaboration with the *North Carolina Society of Hospital Pharmacists.* His foresight and leadership is genuinely appreciated by all members and participants in the group.

My goals as chairman were simple. I wanted to meet bimonthly and create an atmosphere which would be conducive to "idea incubation." Over the past year we have convened on seven occasions.

- May 1, 1994 at Fearrington Pharmacy
- July 11, 1994 at the Institute
- September 7, 1994 at the Institute
- October 26, 1994 at the Institute
- January 27, 1995 at the Institute
- March 24, 1995 at the McIntyre's Conference Room, Fearrington Village
- April 25, 1995 at the Institute

All of the major pharmacy groups in the state have been asked to participate. Communication has been flowing and exuberant. I am very pleased with the spirit of the affair. Implementation of the ideas which have been presented will take years.

First Meeting and Goals

Our first meeting was held at my practice site, Fearrington Pharmacy, on Sunday, May 1, 1994. The meeting was attended by myself, George Peal, Jean Douglas, Steve Fuller, Rick Trivette, and President-Elect Joey Edwards. Our discussions were very definite and resulted in significant actions. President Edwards directed that a conference on pharmaceutical care should be part of our strategic plan. Additionally, on that date, we adopted our mission statement; made decisions to invite representatives from academia, Joe Norwood, and invite third party payers; Andy Barrett, Benny Rideout, and John Zatti. Also the group adopted the following resolution in support of prescription compounding.

Compounding Resolution

Prescription compounding is a right of the pharmacist and can only be performed by the pharmacist or under the supervision of the pharmacist as defined and regulated by the North Carolina Board of Pharmacy. The pharmacist is the only person qualified by education and tradition to compound.

This resolution has been forwarded to the Resolutions Committee, Phil Crouch, Chairman for formal consideration by the Association. Support of pharmacist's right to compound is essential to the practice of pharmacy and to ensure positive patient outcomes. Our committee's intent is to go forward with pharmaceutical care without precluding our historical roles. These must be protected by our spirit and political efforts.

Our group grew to include eleven attendees for the next meeting. Jeff Peterson of Glaxo Wellcome discussed his company's

interest in pharmaceutical care. He provided a synopsis of his discussions with such pharmaceutical care vendors as Pharm Care, CarePoint, and the Minnesota project. He described Glaxo's interest involving three areas. Glaxo needs outcomes data on the use of its products, wishes to see its products used appropriately, and has an interest in seeing that its vendors remain financially viable. His assistance has been valuable in our discussions and in fact for the provision of the funding for conferences.

Pharmaceutical Care Trial

In order to establish a "critical mass" of pharmaceutical care we felt that a trial was needed. The cast needed for such a trial includes pharmacy providers, clinical pharmacists, patients, and payers. Andy Barrett of Pharmacy Network National Corporation advised he was aware of an employer who was interested in such a project. A subcommittee, Steve Fuller, Chair, was formed to develop protocols for this trial. This group has worked diligently to organize and implement our trial. Their efforts have resulted in protocols being written and patients and payers being solicited. Pharmacist providers still need to be assigned and trained. After competency training and physical environment transitions are complete I feel that they will be able to perform the task asked of them. CarePoint is involved in providing training and computer support for documentation in this trial. As I write this report the finalization of all efforts of this exciting event is nearing completion. The summer of 1995 is the projected date of initiation.

CarePoint

CarePoint, Inc. was represented at the September meeting by Mike Groh. Mr. Groh provided us with an abundance of information regarding the significance of pharmaceutical care. CarePoint is well on the way to being a premiere broker of PC. Our continued efforts with this organization seem to be a natural fit to benefit pharmacists and patients in North Carolina. CarePoint provides training and support for pharmacists practicing pharmaceutical care.

The Pharmacy Practice Act

Tim Ives provided information on the need to update the Pharmacy Practice Act. Many pharmacists feel that we need to modify the Act to cover pharmaceutical services, such as working under protocol with physicians and the administration of medications. I support the re-write. I feel that by proceeding with legislation to facilitate the role of the pharmacist as a direct provider of patient care we will be one step closer to being recognized for our services. If we perform in a legally established capacity then this will enable third party payers to compensate us for our professional services. Many of our allied health care professionals do not recognize our role outside the product area. We must strive to establish a pharmacy practice that is not associated with a physical location and is identified by a practitioner with the appropriate coding information to be recognized by payers.

Pharmaceutical Care Conference

Jean Douglas and June McDermott provided the leadership for the pharmaceutical care conference, *Passport to the Future.* This meeting was held on April 1st and 2nd in Greensboro. The two day meeting was widely attended by pharmacists from throughout North Carolina. A distinguished group of multidisciplinary speakers informed the attendees about current pharmaceutical care practice models. The conference consisted of didactic and workshop sessions. Most attendees agreed that implemenatation of the ideas discussed was a very important priority to them. The correct method of implementation is still unclear and needs further definition. The meeting was funded by a grant from the American Society of Health-System Pharmacists, Glaxo, and attendee fees. Jean Douglas wrote the grant for ASHP.



Dean Bill Campbell proudly displays the "Don Blanton Award" for service to Pharmacy during the past year. Photo by Qualex



Curt Sell, left, presents the "McKesson Presidential Award" to Mickey Watts, incoming NCPhA president. Photo by Qualex

Credentialing

We discussed credentialing on several occasions during different meetings. Third party representatives, such as John Zatti of Blue Cross Blue Shield of North Carolina, stated their desire for a professional, consistent, creditable qualification process to ensure practitioner capability. There are at least two national organizations which provide credentials for the various healthcare activities. Three steps were outlined for consideration as levels of participation.

1. Generalist certification.
2. Specialist certification.
3. Primary care certification

By completing these steps of advancement all pharmacists would be able to learn or reinforce practice skills. Payers might then be comfortable with the professional skill level and commitment of the pharmacists involved; however this anticipated comfort level will not necessarily translate to compensation. I feel that two events must occur for payers to universally commit to compensating for PC. First, there must be absolute proof of cost avoidance and secondly, there must be a legal mandate in place describing our role as a provider of service as well as product.

It is entirely possible that the NCPhA could be involved in the credentialing process. We could ensure the quality and context of such a program by performing that task in-house. This concept needs further definition and discussion.

Challenges Remaining

I hope that PC will continue to build momentum as an alternative practice methodology for the pharmacists of North Carolina. Adequate compensation must be provided for these services. This compensation must be timely and quantitatively supportive for the needs of the pharmacist. The continuing challenge for this committee is to assure that these events occur in a timely fashion. In order for this process to be successful the leaders of all the various pharmacy disciplines must support, in spirit and deed, these efforts. I hope that a meeting can be arranged for these leaders which will be universally attended. Such a consensus building push may enable us to gather the support needed to begin mainstreaming our ideas.

Publicity is also needed to educate the consumer about the benefits of our expanded role as direct healthcare providers. Our changing role must be described to them in a positive light to secure their acceptance.

The time for action is upon us. As healthcare reform reconstructs the marketplace we must demonstrate our role as cost-effective direct providers. Then, as the reconstruction proceeds, we will be in a position to administer our professional destiny.

With respect and gratitude,
Julian Harris, Chairman

RITE OF THE ROSES

The Rite of the Roses, a memorial service recognizing those members who have died since the last NCPhA convention, was conducted by Executive Committee member Tom Thutt and Kathy Thutt. The deceased members are:

W. Stanford Tate, Lexington
Daniel E. Rhodes, Morganton
Teresa R. Gerst, Charlotte
Benjamin H. Wolfe, Burlington
John M. Holmes Jr., Surf City
Gilbert Hartis, Raleigh
John A. Dean, Asheboro
James T. Penland, Kinston
Benjamin F. Stone, Elizabethtown
William N. Anderson, Hickory
Charles D. McFall, Madison
Raymond F. Coppedge Jr., Asheville
Grady W. Shuford, Forest City

AROUND THE STATE

Timothy J. Ives, Chapel Hill, has been elected a Fellow of the American College of Clinical Pharmacy (ACCP) and will be recognized at a special ceremony at the ACCP Annual Meeting in Washington, D.C. on August 7. Recognition as a Fellow is accorded members who have demonstrated a sustained level of excellence in clinical pharmacy practice and/or research.

Congratulations to **Steve Moore**, Office of the Surgeon General, Rockville, MD, who was approved as a Fellow of the American Society of Health-System Pharmacists (FASHP). Steve was recognized at a special ceremony at the ASHP Annual Meeting in Philadelphia.

Kathryn F. Kuhn, former NCPhA Director of Professional Affairs, and currently Vice President, Professional and Industry Relations and Conventions and Meetings of NARD, was married March 25, 1995 to N. Kent Covington of Washington. The wedding was held in Historic Westover Church in Charles City, Virginia, with a reception at the Evelynton Plantation on the James River.

Kathryn Krimminger Baddorek (1984) and her husband Detlef announce the birth of their daughter Emma Helena on June 27th. The Baddoreks live in Clemmons.

Sarah Beale Cobb and **Jerry Cobb** are the proud parents of Jerrel Wood Cobb III, to be know as Trey. Trey was born March 2, 1995 at Rex Hospital in Raleigh.

Amy Michelle Carpenter and Joel David Holton were narried March 18 in Rocky Mount. Mrs. Holton is a graduate of the UNC School of Pharmacy and is employed at Bryan Clinic Pharmacy in Tarboro.

Steve Caiola, Chapel Hill recently received the Duquesne University "Dean's Distinguished Achievement Award" for outstanding achievement in pharmacy education.

Jim Baity of Greensboro was presented the Kmart "Pharmacist of the Year" award for excellence in customer care, contributions to the pharmacy profession, involvement in community service and support of Kmart health care activities. Baity was one of four finalists for the national award representing the company's eastern region.
Baity is a graduate of the UNC School of Pharmacy and is an active member in his community. He volunteers his time to United Services for Older Adults, a program that delivers meals to shut-ins, the Greensboro Urban Ministries, where he works as a pharmacist and helps to feed the homeless. He also devotes time to a variety of church activities, the American Red Cross, American Heart Association and Habitat for Humanity.

Obituaries

Malcolm Keith Fearing Jr.
Keith Fearing, past president and recipient of the North Carolina Pharmaceutical Association's Pharmacist-of-the-Year Award died Monday, June 26, 1995 He was 72 years old. A native of Dare County, Fearing was a

Send Us Your News!

If you have news you would like to share in the Around the State column, forward it to the NCPhA office by fax 919-968-9430 or mail it to NCPhA, P.O. Box 151, Chapel Hill, NC 27514

former state legislator and a successful businessman in Manteo. He opened the first pharmacy on the Outer Banks after World War II and was the only pharmacy between Morehead City and Elizabeth City.

Fearing was a prominent civic contributor. He sat on numerous boards and commissions at the local and state level. He was the campaign manager for several successful legislators, including President Pro Tempore of the state Senate, Marc Basnight. In 1994 at a dinner and program at Pirate's Cove he was presented the coveted Mortar-and-Pestle Award, given annually to the North Carolina Pharmacist-of-the-Year. The *Carolina Coast* newspaper described Fearing as 'A rare gentleman, a man whose conduct conforms to a high standard of propriety or correct behavior."

Charles A. Norris

Charles Norris, 61, died May 21 after a brief illness. Norris was a 1955 graduate of the UNC School of Pharmacy and practiced pharmacy in Charlotte and Mount Olive over the past 40 years. In the '60s, he helped set up the Poison Control Center at Mercy Hospital in Charlotte, one of the first in the United States. He served as president of the Mecklenburg County Pharmaceutical Association in 1961-62 and as president of the Wayne County Pharmaceutical Society in 1962-63. Norris was born in Fuquay Springs.

Robert Harrison Barrett II

Bob Barrett, Carthage, died. He was 58 years old and a 1962 graduate of the UNC School of Pharmacy. Barrett was a Life Member of the North Carolina Pharmaceutical Association and former owner of Jonesville Drugs, Inc. in Jonesville. At the time of his death, he was associated with White Star Discount Pharmacy in Liberty in a relief pharmacist role.

C.E. in the Colorado Rockies!



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REGISTRATION: Includes 12 hours of continuing education, full breakfasts for three mornings. Limited space available. Registration for the program is $350 per pharmacist. To reserve your spot, send registration fee or $100 deposit (refundable through November 30, 1995) to the Colorado Pharmacists Association, 7853 E. Arapahoe Ct., Suite 1500, Englewood, CO 80112. Any questions or to receive a program schedule, call the CPhA office at (303) 843-0835.

FACULTY: Program faculty will include nationally recognized experts in their respective fields.

THE TIME: January 21-24, 1996

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Program sponsored by The Colorado Pharmacists Association

CORRESPONDENCE COURSE

PATIENT COUNSELING: OTC DANDRUFF AND SEBORRHEA PRODUCTS



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Dean, and Professor of Pharmacology and Toxicology
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Goals

The goals of this lesson are to describe dandruff and seborrhea and discuss how they can be treated with OTC products.

Objectives

At the conclusion of this lesson, participants should be able to:

1. demonstrate an understanding of dandruff and seborrhea and distinguish between them;
2. choose specific OTC product ingredients that are indicated for the treatment of dandruff and/or seborrhea;
3. exhibit knowledge of cradle cap; and,
4. select from a list, appropriate information to convey to patients when counseling on dandruff and/or seborrhea remedies.

Dandruff and seborrhea dermatitis (seborrhea) are afflictions for which pharmacists are called upon to suggest treatment. While the two disorders have pathologically different etiologies, it is not always easy to distinguish between them. Unless the conditions are severe, both can be managed effectively with the same OTC products.

Anatomical/Physiological Considerations

The skin's cells are formed continually in the basal (lower) level of the epidermis. They divide by mitosis to form daughter cells which then migrate upward toward the skin's surface. As they approach the surface, they die and become dehydrated because the upper layers of the epidermis are not supplied with a nutrition source. The skin's vascular supply is limited to the dermis. These highly compacted (dry) cells are known collectively as the keratin layer, and as a result of normal shedding forces on the skin, with replacement from cells underneath pushing upward, the outermost dead epithelial cells slough off. This process is

continuous and since the cells are normally shed individually, shedding is usually imperceptible.

In dandruff and seborrhea conditions, however, the shedding rate of these cells is excessive. When they come off in large clumps, the conditions are perceivable as dandruff and seborrhea.

Dandruff

Dandruff is defined as a chronic, noninflammatory condition of excessive shedding of epidermal cells that come off in large clumps or scales. Dandruff scales appear dry, white or grayish. They are most commonly seen in small, round patches, especially on the crown of the head. However, when the condition is severe, these patches may cover the entire scalp. Dandruff itself causes occasional itching, but this is the exception. Generally, itching may indicate the presence of some other dermatitis related condition.

One hypothesis that still has some proponents, even though it has been shown not to be significant, is that dandruff is caused by a yeast-like fungus. The presence of *Pityrosporum ovale* was first observed years ago on the scalp of victims of dandruff. However, today it is generally agreed by most experts that P. *ovale* can be found on the scalps of *all* persons.

Other microorganisms have also been proposed as possible causes of dandruff. At presen, it is impossible to determine definite conclusions on any of them. One particularly interesting note is that the organism *Propionibacterium acnes* is frequently *decreased* significantly on scalps of individuals who have dandruff. This microbe is associated with acne.

Symptoms and Occurrence.

The most visible symptom of dandruff is scaling of large clumps of cells called squamae. This flaking is seasonal, being most severe from October through December, and least common during the summer months. These associations probable reflect seasonal humidity conditions (i.e., low humidity: dandruff present; high humidity: little dandruff problem). Dandruff is also subject to several other features (Table 1),

Table 1
Important Characteristics of Dandruff and Seborrhea

Characteristic	Dandruff	Seborrhea
Site	Scalp	see Table 2
Borders	Indistinct	Indistinct
Inflammation (redness)	No	Yes
Appearance of scales	Dry, grayish-white	Greasy
Age at onset	Puberty	Puberty
Itching	Variable	Usual
External factors that worsen condition	Cold weather	Stress, poor health
Rate of epidermal	Twice normal rate	More than twice normal turnover rate
Duration	Can persist for life, diminishing in middle and old age	Can persist for life, frequent exacerbations and remissions

Cause. The actual cause of dandruff is not known. It is not caused by poor hygiene, although poor hygiene may exacerbate a pre-existing condition.

Other theories associate dandruff with improper diet, hormone imbalance, or vitamin B complex deficiency. None of these have been proven, however.

all of which can be used to differentiate the condition from seborrhea.

Dandruff generally begins with the onset of puberty and peaks in intensity in the early twenties. It declines in middle and old age. Estimates suggest that as many as 70 percent of all Americans have been afflicted with it at some time. Members of both sexes are affected equally. While sometimes described as a trivial condition, it is only trivial to the person who does not suffer from it. The large number of proprietary products available for treating dandruff attests to this.

Seborrheic Dermatitis

With seborrhea, the rate of turnover of epithelial cells is even greater than in dandruff. Dandruff is localized almost entirely to the scalp. Seborrhea is also encountered mostly on the scalp (seborrhea capitus), but it may also occur on other hairy areas of the body and in the skinfold regions. Sites of occurrence are listed in Table 2. These areas contain the highest concentration of sebaceous glands, as well as the largest concentration of skin bacteria and yeasts.

Causes. As with dandruff, numerous theories have been advanced over the years concerning the pathogenesis of seborrhea. Likewise, the precise cause is not known.

One theory states that excessive secretion of sebum induces seborrhea by providing a rich oily substrate for bacteria and fungi to metabolize into irritating substances (e.g., free fatty acids). Even though the name seborrhea defines excessive sebum flow, it has not been shown that all persons with the condition have increased sebum production. In fact, in carefully controlled tests, patients with the disorder often do not have increased sebum production when matched to their age-related counterparts.

The condition has also been linked to fungi and bacteria. For example, Candida organisms are present in significantly higher numbers in infants with cradle cap. P. *ovale* and *Staphylococcus aureus* are found in higher than normal concentrations in patients with seborrhea. The concentration of P. *acnes* is more depressed in persons with seborrhea, than in those with dandruff.

Other suggestions as to etiology suggest that seborrhea may be due to food allergies, vitamin B complex deficiency, an autoimmune deficiency, or to changes in weather. None of these has been proven, however.

Cradle Cap. This condition may represent an infantile form of seborrhea. It involves the scalp, skin behind the ears, nasolabial fold, neck, armpits, umbilicus, and diaper area. The prevalent age for cradle cap on the scalp is within the first couple of weeks of life. It results from accumulation of keratin and dirt. The likely reason for its occurrence is that mothers are hesitant to wash the area, fearing that if too much pressure is applied to the "soft spots" on the baby's head, permanent brain injury will result. This is, of course, an unfounded fear.

The condition normally clears within a month and generally does not recur. Rarely, it may evolve into dermatitis with itching, and spread to the cheeks, forehead and extremities. Except for these severe cases, cradle cap can be controlled by careful and thorough washing with soap and water. There are no longer any OTC products labeled specifically for use on cradle cap.

Symptoms and Occurrence. Although the two conditions differ considerably, symptoms of seborrhea resemble dandruff in several important ways. Seborrhea produces dull, yellowish-red lesions. They

Table 2
Usual Sites for Seborrhea

Armpits
Back between shoulder blades
Behind the ears
External ear canal
Eyebrows and eyelashes
Mid-chest
Nasal folds
Pubic area and groin
Scalp

are localized on one area of the scalp or hairy surface, but the condition may be more diffuse with large areas being affected. Unlike dandruff, itching is common with seborrhea.

Seborrhea fluctuates in severity. Whereas dandruff occurs at a relatively stable intensity, seborrhea can be severe one time, quite mild the next, then again severe in its next occurrence. Seborrhea appears during times of stress. It is characterized by inflammation and crusting, and may involve the eyebrows and eyelashes and cause blepharitis (inflammation of the eyelids).

The condition is seen most commonly in middle-aged individuals and the elderly. Women are affected more frequently than men. It rarely occurs in children. About 12 million Americans are reported to suffer from seborrheic dermatitis.

Treatment of Dandruff and Seborrheic Dermatitis

There are no definitive cures for either condition. Regular use of OTC remedies can control symptoms. Many individuals rely on the principle that if the large clumps or flakes can be reduced in size, their visibility decreases, and hence, the dandruff condition will be "controlled." Regular washing of the hair and scalp helps a great deal. This can be done daily, although once every second or third day is usually sufficient, except in severe cases.

The classification of OTC agents is presented in Table 3. Categorizing the agents is difficult because two or more effects may be attributed to the same ingredient.

Dandruff

Antiseptics (antimicrobials). Because of the theory that microorganisms are a possible cause of dandruff, antiseptics have been employed to treat this condition. These include benzalkonium chloride, iodoquinol and povidone iodine. Their inclusion in OTC dandruff remedies is of questionable value since the microbialinduced dandruff theory is not proven, and secondary infection from dandruff is rarely encountered.

Keratolytics. These agents cause a peeling away of the keratin layer, thus removing the scales. Most likely, keratolytics work by dissolving the cement substance that holds the cells together, rather than by dissolving keratin. As the scales are loosened, they can be washed away easily. Keratolytics do not prevent scales from forming.

Cytostatics. Use of cytostatics (e.g., selenium sulfide, zinc pyrithione) is a direct means to control dandruff. They decrease the rate of cell growth. Thus, scaling is reduced because there are fewer cells formed per unit of time. These agents lower epithelial cell turnover significantly, not only those on the scalp, but also of cells elsewhere that come into contact with the medication.

Antipruritics and Corticosteroids. Since sensations of pain and itching are transmitted by the same nerve fibers, local anesthetics have been included in some dandruff products in the past. Hydrocortisone is also antipruritic, so its use in dandruff control could be rationalized. However, dandruff is not an inflammatory condition. While hydrocortisone has been ruled to be safe and effective for the treatment of seborrhea, it cannot be indicated for dandruff. As was mentioned before, itching is not a major complaint with dandruff.

Tar Preparations. While the mechanism of their action is unknown, tar preparations probably act either as cytostatics or keratolytics.

Seborrheic Dermatitis

As stated earlier, misdiagnosis of seborrhea of the scalp as dandruff is not a serious problem. Both conditions are treated basically the same way. In fact, may products are labeled with both indications. Mild seborrheic conditions are treated basically the same way. In fact, many products are labeled with both indications. Mild seborrheic conditions can be treated with OTC products. If the seborrheic condition involves the ear canal, its treatment is best supervised by a physician.

Coal tar. In strengths of 0.5 to 5 percent, coal tar is safe and effective for both dandruff and seborrhea of the scalp. Patients should be reminded that coal tar can stain clothing, skin and hair (especially gray, blond or bleached). Also, it imparts a strong odor that is objectionable to some people.

Coal tar can cause photosensitivity reactions in susceptible persons. Therefore, patients should avoid excessive sun or ultraviolet light exposure for at least 24 hours after applying the product.

Salicylic Acid. In strengths of 1.8 to 3 percent, salicylic acid is an effective keratolytic for treating dandruff and seborrhea.

Sulfur. In a concentration of 2 to 5 percent, sulfur is safe and effective for treating dandruff. Though not approved for OTC sale for self-treatment of seborrhea, sulfur continues to be recommended by medical authorities. A concentration of 3 to 5 percent, combined with salicylic acid, can be applied to the scalp or other sites on the body.

Selenium Sulfide. For years, a 1 percent concentration of selenium sulfide has been considered to be effective for controlling both dandruff and seborrhea.

Discoloration of the hair has been noted following use of selenium sulfide. However, this isn't a common occurrence. Patients with dyed hair should first test a small area with the shampoo to be certain no staining will occur. The shampoo should also be rinsed off thoroughly after use. FDA requires manufacturers of selenium sulfide products to state the following warning on product labels: "Do not use if you have open sores on your scalp."

In January 1994, FDA approved the addition of selenium sulfide, micronized—a finely ground formulation that has a smaller particle size than the previously available form—to the list of safe and effective agents, in a 0.6 percent concentration.

Zinc Pyrithione. This is safe and effective for controlling dandruff and seborrhea. Concentrations that are approved for marketing as a formulation to be applied and then washed off after brief exposure are 0.95 to 2 percent. Formulations to be applied and left on the skin or scalp must be in the 0.1 to 0.25 percent range.

Table 3
Dandruff/Seborrhea Remedies Safe and Effective for OTC Use

	Dandruff	Seborrhea
Coal tar derivatives (shampoos)	X	X
Salicylic acid	X	X
Selenium sulfide	X	X
Sulfur	X	
Zinc pyrithione	X	X
Salicylic acid/ sulfur combos	X	

Advising Patients on Treatment of Dandruff and Seborrhea

In addition to information discussed thus far, a few other points should be passed on to patients purchasing dandruff or seborrhea remedies.

The hair and scalp can be washed with a regular shampoo prior to using the medicated product to enhance the latter's effectiveness. This helps remove dirt and flakes, and allows for enhanced penetration of the medicated product into the scalp. Another shampooing with a nonmedicated product may be considered following removal of the remedy. This can eliminate the objectionable odors and discoloring that some dandruff and seborrhea products impart to the hair and scalp.

The medicated shampoo should be applied and left in place for the time specified on its label. A minimum period is 5 to 10 minutes. Brushing the hair with a soft-bristle brush may assist in getting the product worked down to the scalp.

Selenium sulfide may impart oiliness to the scalp and thus worsen the seborrhea. Its use for this condition should be limited to once every second or third day. If the scalp is especially oily, a product containing

salicylic acid and/or sulfur may be more beneficial.

With any OTC dandruff or seborrhea product, patients should avoid contact with the eyes or mucous membranes. If contact occurs, the area should be flushed thoroughly with water.

OTC products for dandruff and seborrhea work well for most people. However, if a product fails to provide relief, another one that has different ingredients and mechanism of action could be tried. If such products still do not correct the problem, the individual should contact a physician. The person may have a disease more serious than simple dandruff or seborrhea.

OTC products for dandruff and seborrhea should not be used on children under two years of age, unless under the supervision of a physician. This precaution is warranted because their skin surface in proportion to body weight is greater than that of adults. Furthermore, children do not have a fully developed hepatic microsomal enzyme system, so they cannot metabolize potentially toxic substances that are absorbed as well as adults can.

To avoid possible damage to the eye, seborrheic conditions that involve the eyelids should only be treated by a physician and not be self-medicated.

FDA requires the following instructions for these products, and they should be reinforced:

(a) For all products to be applied and washed off (e.g., shampoos and pre/post shampoo rinses): "For best results, use at least twice a week or as directed by a doctor."

(b) For all products to be applied and left on the skin or scalp (e.g., creams, ointments, lotions, hairgrooms): "Apply to affected areas once to four times daily or as directed by a doctor."

Patients should be instructed to seek professional assistance if their condition does not improve within several weeks of using a medicated shampoo. This advice is also valid if the condition appears on other areas of the body.

CONTINUING EDUCATION QUIZ

Patient Counseling: OTC Dandruff and Seborrhea Products

1. Which of the following is a true statement?
a. Dandruff scales are dry, seborrheic scales are greasy.
b. Dandruff scales are greasy, seborrheic scales are dry.
c. Both dandruff and seborrheic scales are dry.
d. Both dandruff and seborrheic scales are greasy.

2. All of the following are indicated for treating both dandruff and seborrhea EXCEPT:
a. coal tar.
b. retinoic acid.
c. selenium sulfide.
d. zinc pyrithione.

3. The large lumps of cells that shed off the scalp in dandruff are called:
a. eczema.
b. plaque.
c. squamae.
d. psoriasis.

4. The most common cause of cradle cap is:
a. a surge of hormone production.
b. excessively slow formation of keratin cells.
c. improper washing of the affected area.
d. an allergic reaction to detergents.

5. Selenium sulfide and zinc pyrithione are classified in which of the following therapeutic groups?
a. Keratolytic
b. Antimicrobial
c. Cytostatic
d. Antipuritic

6. Dandruff and seborrhea occur when the shedding rate of keratin cells is:
a. nonexistent.
b. excessive.
c. stagnant.
d. insufficient.

7. Dandruff and seborrhea are similar in that they both:
a. onset at puberty.
b. cause greasy scales.
c. produce inflammation and redness.
d. only occur on the scalp.

8. Patients with seborrhea should seek professional assistance in all of the following situations EXCEPT:
a. when it is on the eyelids.
b. when it does not improve within several weeks of using a medicated shampoo.
c. when it occurs on children under two years.
d. when it occurs on the scalp.

9. The organism whose concentration on the affected area is depressed in persons with seborrhea is:
a. *Candida albicans.*
b. *Pityrosporum ovale.*
c. *Staphylococcus aureus.*
d. *Propionibacterium acnes.*

10. All of the following statements about skin cells are correct EXCEPT:
a. they are formed continually in the epidermis.
b. they divide by mitosis.
c. they migrate upward toward the skin's surface.
d. they die and become hydrated.

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JOURNAL OF PHARMACY

(USPS 091-280)

Nov/Dec 1995 **Volume 75** **Number 6**

ISSN 0528-1725

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The Carolina Journal of Pharmacy is published bi-monthly by the North Carolina Pharmaceutical Association, P.O. Box 151, Chapel Hill, NC 27514. *The Journal* is provided to NCPhA members through allocation of annual dues. Subscription rate to non-pharmacists is $25.00 (continental U.S.). Overseas rates on request. Second class postage paid at Chapel Hill, NC.

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HIGH NOON AT GRANDY DRUGCARE

Thousands of community pharmacists in every state in the union participated in NARD's "High Noon for Your Local Pharmacy." Many North Carolina pharmacists took part in the opportunity to make people aware of what is really happening to their pharmacy benefits, their freedom of choice, and their health benefit dollars.

North Carolina's own Don Heaton of Currituck, who operates the only pharmacy in Currituck County, says the High Noon rally he held at his pharmacy made his patients more aware of some of the reasons behind their dwindling pharmacy choices.

"People weren't making the connection between insurance company and health plan practices and the death of their own freedom of choice," said Heaton. "They don't appreciate being forced out of their community pharmacy and into mail order plans, but they hadn't heard the story behind that reality—the story of community pharmacies like mine who are quietly losing their patient base. They had no idea what they could do to reverse that process."

Heaton, who collected a whopping 272 ballots during his rally, released black balloons to symbolize the death of pharmacy freedom of choice. His staff wore black armbands and he hung black sheets and displayed black floral arrangements on tables in front of his pharmacy, where he provided names and addresses of members of Congress. "We still have the black drapes up in the store," he noted, "and they still spark questions from our patients."

Heaton credits employee Melody Singler with a gargantuan effort in organizing the rally, especially in terms of securing media coverage. The rally received coverage in the *Coastland Times* and the *Currituck Times*, along with local television coverage—a mixed blessing, as it turned out.

"One of the local television stations, which had agreed to cover the event, backed out at the last minute because of other breaking news," reported Singler. "I put the pressure on, and they did end up sending a camera person. Unfortunately, without a reporter to do some interviews and collect information, the one-and-a-half hours of film the camera person took ended up as a two-minute spot that gave the impression that our store was going out of business. We did get a lot of calls on that!"

Reprinted with permission from the NARD Journal, November 1995.



Don Heaton of Grandy Drugcare in Currituck speaks to a group of over 100 concerned citizens outside his pharmacy.

1995 Recipients of the "Bowl of Hygeia" Award



Wyeth-Ayerst Laboratories takes great pride in continuing the "Bowl of Hygeia" Award Program developed by the A. H. Robins Company to recognize pharmacists across the nation for outstanding service to their communities. Selected through their respective professional pharmacy associations, each of these dedicated individuals has made uniquely personal contributions to a strong, healthy community which richly deserves both congratulations and our thanks for their high example.

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PLAN TO FORCE MEDICARE FEDERAL RETIREES INTO UNREGULATED MAIL ORDER PHARMACY

Taking swift action on behalf of the nation's community pharmacists, NARD attacked the recently announced Blue Cross/Blue Shield prescription drug program that coerces federal retirees with Medicare coverage into obtaining their prescription medications from unregulated mail order pharmacies.

"The Blues' new plan is an insult to Medicare beneficiaries who happen to be federal retirees," said NARD President Louis Mitchell. "By forcing federal retirees with both the Blue Cross Standard Option and Medicare Part B insurance to abandon their local pharmacy, Blue Cross is consigning several hundred thousand seniors to substandard pharmacy practice through the mail that potentially jeopardizes their health.

"The Blues' new plan is an insult to Medicare beneficiaries who happen to be federal retirees."

"Seniors take three to four times as many medications as the average American," said Mitchell. "They are the ones most in need of the careful, face-to-face monitoring by their neighborhood pharmacist, not an unregulated mail order pharmacist located hundreds of miles away. You simply cannot professionally monitor the care of patients you never see."

Effective January 1, 1996, the Blue Cross prescription drug plan for federal employees and retirees who select the Standard Option and are also covered under Medicare Part B requires no copayment if the enrollees mail away for their medications. But it creates a new 20 percent copayment for enrollees who wish to continue to receive their medications from a Blue Cross/PCS preferred neighborhood pharmacy. The average Medicare federal retiree will now have to pay $450 out of pocket each year to continue to patronize a preferred pharmacy.

In a Fax Alert sent last week to several thousand NARD member pharmacies and in the November issue of the *NARD Newsletter*, NARD launched a two-pronged assault on the new Blues' program. Adopting a strategy used with great success in NARD's recent "High Noon for Your Local Pharmacy" day of protest, NARD is encouraging pharmacists to capitalize on widespread patient discontent with the anti- consumer practices of health insurers like Blue Cross.

In the Fax Alert and in the NARD Newsletter, texts for a patient petition and two patient handouts were included for pharmacists to put to use immediately in their pharmacies. The materials encourage Medicare federal retirees to ask their pharmacist to help them select safer, higher-quality prescription drug benefits than those offered by the Blues during the November 13–December 11 "Open Season" in which Federal Employee Program enrollees are free to switch their health benefits coverage.

As the second part of the effort, NARD is urging all community pharmacists to call or fax their concerns immediately to Congress and to the Blues, so that their views will be heard during the "Open Season" for Federal Employee Program enrollees. NARD is asking Congress and the Blues to at least equalize the copay for the preferred neighborhood pharmacy and mail order pharmacy options.

"The health risks of using unregulated mail order pharmacies are well documented," said NARD Executive Vice President Charles West. "If anything, Blue Cross should charge federal retirees more to use this dubious form of pharmacy. At the very least, the copays should be equal—either Medicare federal retirees should pay no copay for prescriptions from preferred pharmacies or unregulated mail order pharmacies, or they should pay the same copay to both.

"The calculated indifference of the Blues to

the legitimate pharmacist care needs of Medicare federal retirees is yet another example of middlemen and bureaucrats inappropriately intervening in the patient-pharmacist relationship," said West. "This is not managed care, it is mangled care, and Medicare beneficiaries are the ones who will suffer."

In addition to the grassroots efforts, NARD has launched a direct lobbying effort on Capitol Hill on behalf of its members and the Medicare-covered federal retirees they serve. The opposition to the Blues' plan is part of NARD's ongoing High Noon Campaign against the ill-conceived, anticonsumer practices of many health insurance companies.

The new Medicare 20 percent copay for preferred pharmacies would seriously undermine the face-to-face relationship such federal retirees have long had with their community pharmacists—one that NARD fought hard to maintain just three years ago. In 1992, Blue Cross proposed to cut nearly all independent community pharmacies out of their preferred network for federal employees. A massive, NARD-orchestrated grassroots effort ensued, and the Blues network was eventually opened to all pharmacies.

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Mr. Robert Copeland, Vice President
Health Care Services, Blue Cross Blue Shield of NC
P.O. Box 2291
Durham, NC 27702

Dear Mr. Copeland:

I have had the opportunity to review the recent Blue Cross/Blue Shield of North Carolina Participating Pharmacy Agreement. I found it interesting that the Agreement focuses on the cost of the drug product and reimbursement for the drug product. The Agreement outlines hours of operation, requires a designated patient counseling area and calls for the provision of literature with the dispensing of prescription drugs. Additionally, the Agreement requires the pharmacist to monitor for problems such as delayed refills, overlapping drug therapy, correct dosages and the appropriateness of dose and drug for the patient's disease state. I could not find, however, any mention of reimbursement for the professional services required by the contract.

Shown below are the results of a recently completed pilot study in two similar rural health clinics comparing ten matched pairs of patients with asthma. In the study group, a pharmacist intervened to educate patients about their disease and proper use of medications. No pharmacist's intervention occurred in the control group. Results show that for the ten intervention patients, the cost of medications was about $2,000 higher, but the total cost of clinic and hospital visits was $5,400 less over the one-year study period. Projecting this savings to a larger group would reflect a substantial savings resulting from pharmacist intervention.

Representatives from the Pharmaceutical Care and Practice Committee, a joint committee from the North Carolina Society of Hospital Pharmacists, the North Carolina Pharmaceutical Association and other health related organizations would like to meet with you to discuss the implementation of reimbursement for professional services by Blue/Cross/Blue Shield of NC.

Sincerely,
June H. McDermott, M.S. Pharm., M.B.A.
Clinical Assistant Professor, UNC School of Pharmacy

Editor's Note: This letter was edited for publication.

ROANOKE AMARANTHE RURAL HEALTH GROUP
ASTHMA INTERVENTION PROJECT RESULTS

	RACHG (study)	LAKE GASTON (control)
Number of Patients (patients matched by age, race, disease severity)	10	10
Pharmacist Intervention	Yes	No
Costs		
Clinic Visits	$1496	$2044
Out/In-Patient Hospital Visits	864	5730
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about the Directory...

The Pharmaceutical Directory is provided as a member service by the North Carolina Pharmaceutical Association. This is the sixth issuance of this directory and we try to improve upon the accuracy and resourcefulness of the information with each publication. It contains many of the most frequently requested telephone numbers, addresses and other information about national, state, and local pharmacy organizations, health care organizations, third party administrators, and state and federal government offices.

NCPhA staff has tried to make this list accurate and complete, with the help of many members who provided information. We encourage you to review the directory and notify us at once with any more current information or corrections. We also ask you to suggest additions to the directory for next year's issue. You can contact the NCPhA office at 800-852-7343.

1995-96

NCPhA

Pharmaceutical

Directory

To be reviewed, checked for accuracy and retained for reference

local pharmaceutical associations

Alamance Pharmaceutical Society
President, Elmo McCorkle, 1321 N. Sellars Mill Rd., Burlington, 27217, (910)226-1635
Sec.-Treas., Jack G. Watts, 444 Tarleton Ave., Burlington, 27215-4908, (910)226-5681

Blue Ridge Pharmaceutical Association
President, Steve Critz, 104 Cowles St., N. Wilkesboro, 28659, (910)651-8100
Vice Pres., Larry Irwin, 411 Hawthorn Rd., Elkin, 28621, (910)835-6627
Treas., Jim Worley, 216 Gaddy's Ridge Rd., Wilkesboro, 28697, (910)838-7356
Sec., Lois Koontz, P.O. Box 1205, Jefferson, 28640 (910)667-5200

Cape Fear Pharmaceutical Society
President, Amy Bowden, 1136 Dunn Rd., Fayetteville, 28301, (910)425-7059
Vice Pres., Martha Epps, 4404 Owen Dr., Fayetteville, 28301
Sec-Treas., Jim Cash, 202 W. Broad St., St. Pauls, 28384, (910)865-4134

Catawba Valley Society of Pharmacists
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Vice Pres., Jerry Jackson, 101 Everett Dr., Granite Falls, 28630, (704)396-3063
Sec., Bill Means, 649 5th St. NW, Hickory, 28601, (704)322-7719
Treas. Don Johnston, 1021 13th Ave. NW, Hickory 28601, (704)322-7717

Cleveland County Pharmaceutical Association
President, Lori Wilson, 822 E. Graham St., Shelby, 28150, (704)484-8808
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(to reserve meeting space)	Rhonda Horner/Terri Little/Cathy Jordan
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AROUND THE STATE

BUIES CREEK—Dr. Carolyn Smoak, DVM, PharmD, a resident in Drug Information at the Campbell University School of Pharmacy is the 1995 recipient of the Facts and Comparisons Inc. Scholarship for Postgraduate Study in Drug Information. The criteria for awarding the scholarship included academic achievement scholarly activities and professional attributes.

HICKORY—Retired pharmacist **Bill Stedman**, recently received praise in his local newspaper for his volunteer efforts at the Greater Hickory Corporate Christian Ministry. Stedman was instrumental in starting the ministry, which is focused on helping people who do not apply for public assistance, but cannot afford medications. Stedman, who volunteers two days per week, says his volunteer job not only helps others, but it also keeps him mentally alert.

STATESVILLE—Donnie Bowers, owner of Cooke's Pharmacy and member of the NC Team in Training Program, will be running in the 26.2 mile Walt Disney World Marathon on January 7, 1996 to raise money for six-year-old Nicky Bayne of Statesville, who has been diagnosed with acute myelogenous leukemia (AML). This is the second year Bowers has taken part in the Training Team, comprised of over 10,000 participants nationally.

HICKORY—Tad Adams was recently named Catawba Memorial Hospital's C.A.R.E. Employee of the Month for August. The award recognizes and rewards employees who exhibit courtesy, a positive attitude, respect for patients and co-workers, and enthusiasm for their job. Adams, a UNC School of Pharmacy graduate, is an assistant director for clinical services for the hospital pharmacy.

WEDDINGS

TROY—Julie Burnette and **Andrew Castelloe** were married on July 8. Andrew, a UNC School of Pharmacy graduate, is employed by Revco in Albemarle.

SILER CITY—Lisa Moonschein and **William Duke** were married on July 22. William, a UNC School of Pharmacy graduate, is employed by Revco.

LUMBERTON—Nicole Lowery and Timothy Locklear were married on August 19. Nicole is a 1994 UNC School of Pharmacy graduate. She is employed by Revco in Lumberton.

OBITUARIES

ELIZABETH CITY—Arthur Etheridge Brothers, 72, died August 23, 1995. Arthur was one of the pharmacist-owners of Overman and Stevenson drug store for more than 40 years. He was a graduate of the UNC School of Pharmacy and served in the Air Force during World War II. Brothers was a member of the North Carolina Pharmaceutical Association and the First United Methodist Church.

BURLINGTON—Robert A. Coleman, 62, died on December 22, after several months of failing health. Coleman was a past owner of Haw River Rexall Drugs and, at the time of his death, was working at Revco in Glen Raven. He was a member of the North Carolina Pharmaceutical Association. He was an Army veteran.

Send Us Your News!

If you have news you would like to share in the Around the State column, forward it to the NCPhA office by fax 919-968-9430 or mail it to NCPhA, P.O. Box 151, Chapel Hill, NC 27514.

KENANSVILLE—Joseph Earl Hatcher, 66, died September 10. Hatcher was a UNC School of Pharmacy graduate and co-owner of Kenansville Drug for 40 years and a partner in the Faison Pharmacy for 15 years. He was a veteran of the U.S. Army, a member of the North Carolina Pharmaceutical Association, a former mayor and town councilman of the Town of Kenansville, and past member of the Duplin General Hospital Board of Trustees.

EDENTON—William Herbert Hollowell Jr., 74, died September 27 after a battle with cancer. He was a 1944 graduate of the UNC School of Pharmacy. Hollowell's employment began during World War II in the U.S. Navy from 1944 until 1946 where he served as the Director of Pharmcy at the Camp Lejeune Naval Hospital. From 1957 until 1989, he was the owner of Hollowell's Drug Store in downtown Edenton. Hollowell was very involved in community activities, where he held a number of leadership positions and received many awards for his efforts of good will.

EDENTON—John Agrippa Mitchener Jr., 81, died October 11. He was the owner/operater of Mitchener Pharmacy and was a former mayor of Edenton.

Mitchener graduated in 1937 from the UNC School of Pharmacy and worked in the firm established by his father in 1906. He was active in regional, state and national pharmacy societies including the National Association of Retail Druggists, the Northeastern Drug Club, and a life member of the North Carolina Pharmaceutical Association. In 1993, he was the North Carolina recipient of the Wyeth Robins "Bowl of Hygeia Award" for outstanding community service beyond the normal scope of community pharmacy involvement.

An active community leader, Mitchener served as an Edenton town councilman from 1951 until 1959, from which time he served as mayor until 1969. He was a member, deacon and elder of First Presbyterian Church of Edenton. Mitchener was actively involved in a number of civic groups and served in various leadership roles.

BILL JACKSON JOINS RESIDENT CARE PHARMACY STAFF



Resident Care Pharmacy, a long-term care pharmacy in Ayden, recently added pharmacist Bill Jackson to its growing staff.

Mr. Jackson graduated from the UNC School of Pharmacy in 1973. He was president of the pharmacy school student body and a member of Rho Chi National Scholastic Honorary Pharmaceutical Fraternity.

He is a past chairman of the North Carolina Pharmaceutical Association Legislative Committee and a current member and past chairman of the board of directors of the Alpha Gamma Chapter of Phi Delta Chi, Inc. pharmacy fraternity.

Mr. Jackson brings extensive experience to the position with over 22 years as a pharmacist in Oxford.

"We are thrilled to have Bill on our team," said Ernie Hargett, director of pharmacy services. "He is an exceptionally motivated individual with an outstanding background and credentials."

Resident Care Pharmacy is a provider of medication management systems for long-term care facilities and their residents, specializing in subacute care. Resident Care provides pharmaceutical care for over 2000 residents of nursing facilities throughout North Carolina.

From the Schools

Campbell University School of Pharmacy

Kappa Epsilon Pharmaceutical Fraternity at Campbell University School of Pharmacy has established a professional project geared towards developing public awareness of the pharmacist's role in the health care system. Using the video titled "Your Prescription, Your Pharmacist and You," by Glaxo and APhA, the members of a newly established committee have been making presentations to civic groups in the surrounding areas of Buies Creek.

The program began as a pledge project in the Spring of 1995, with a presentation by Dena Askew, Wendy Adkins, Susan Miller, Kathy Carswell and Dr. Connie Fleming to the Coats Kiwanis Club. Since then, this program has been presented to the Women of Coats First Baptist Church, and Coats Lion's Club respectively. The feedback and participation from attendees has been excellent, and we have had many requests from other organizations to speak at their functions as well.

Future presentations are being planned as more KE Sisters become trained. Our goal is to make even more people aware that indeed, pharmacists are the most accessible sources of vital health care information available.

Submitted by Dena Askew
Class of 1998

UNC School of Pharmacy





The UNC Kappa Psi pledges from the Beta Xi Chapter were recently employed by NCPhA for gardening services. Pledges weeded and pruned the very needy rose garden at the NCPhA headquarters. How were they paid? Pledge hours, of course! *Special thanks from all of us here at NCPhA for their hard work.*



CORRESPONDENCE COURSE

PATIENT COUNSELING: NEW DRUGS OF 1994-95
PART 1: ANTIDEPRESSANT AGENTS



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Ada, Ohio



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University of Cincinnati
Cincinnati, Ohio

Goals

The goals of this lesson are to identify and discuss new drugs introduced to the marketplace in 1994 and 1995, with special emphasis given to the new antidepressant drug venlafaxine.

Objectives

At the conclusion of this lesson, successful participants should be able to:

1. exhibit knowledge of the pharmacologic classification and therapeutic considerations for venlafaxine;
2. select from a list, the indications, mechanisms of action, benefits and limitations of venlafaxine;
3. identify adverse effects, major toxicities, and drug interactions associated with venlafaxine as compared to previously available antidepressants; and,
4. demonstrate an ability to counsel patients on antidepressant drugs.

This lesson reviews the antidepressant drug venlafaxine (Effexor). Its dosage forms and regimens are listed in Table 1. Another antidepressant, fluvoxamine, which had just been approved by FDA at the time of original publication of this lesson, is a serotonin-specific reuptake inhibitor similar to Paxil, Prozac and Zoloft.

The "1S" notation after the drug name signifies that the drug went through the standard FDA approval process.

Depression

Before discussing antidepressants, a short review of depression is in order. All individuals become depressed from time to time due to death of a loved one, loss of a job, etc. For most people it is a temporary condition. However, some people need counseling or drug therapy to overcome their low-level psychic mood and/or self-esteem.

It has been reported that depression is the most common psychiatric disturbance seen by physicians. As much as 10 percent of the adult population experiences clinical depression at some time.

Depression reportedly occurs nearly twice

Table 1
New Antidepressant Agent

Generic Name	Trade Name	Availability	Dosage Regimen
venlafaxine (1S)	Effexor	25, 37.5, 50, 75, and 100 mg tablets	75 mg per day in 2 to 3 divided doses titrated up to 225mg/day

as often in women than men. For women the peak age range for clinical depression is 35 to 45 years. Depression in men usually occurs later in life.

One of the difficulties with the diagnosis and treatment of depression is the subjectiveness of symptoms. This means that there is no machine or instrument like a sphygmomanometer or MRI that can measure the occurence or extent of depression. It can only be discovered by observing certain signs and symptoms and then interviewing the patient to see how she or he perceives life overall.

The exact mechanisms of action of psychotherapeutic drugs or how to select the best drug for a given patient have yet to be determined. Therefore, the treatment of depression today is more of an art than a science.

It is known that the thought process is a series of chemical reactions that determine, through sight, touch, sound and the other senses, what is going on in the environment. These sensations are transmitted to the brain along neurons from the periphery, through the spinal cord, to lower parts of the brain and the cerebral cortex. As they pass through the lower brain where memory and emotions are stored, these messages are matched and compared against one's previous experiences. They are assigned an "I like this," or "I don't care" component. The impulses then reach higher centers of the brain and the individual perceives "reality."

This is just one of several theories on thought, but there is much evidence that each individual perceives things differently, because everyone has different life experiences. This theory goes on to state that the thought process is a series of reactions involving dozens, if not hundreds, of chemicals (neurotransmitters). A person's perception of reality depends on the proper "balance" of chemical reactions involved in the thought process.

At this time, there is no predetermined level for each chemical released during the thought process, or what the relative balance of these chemicals should be. However, given that some neurotransmitters are stimulatory and others inhibitory, this theory concludes that when the neurotransmitters are in balance, the individual is mentally healthy and functioning "normally." When the balance is disturbed, he becomes anxious or depressed, and cannot return to normal functioning without help.

The classic signs of depression are false beliefs, held onto with the conviction that they are correct. Depressed patients have severe feelings of guilt, low self-esteem, high levels of pessimism and self-pity, loss of energy and interest in previously enjoyable activities, and they frequently withdraw from society. Some depressed patients believe suicide is the only answer to their misery. It is estimated that 15 percent of patients with major depression will attempt suicide.

The need for proper diagnosis and treatment is essential since suicide is the eighth leading cause of death in American adults and the second leading cause of death in people between the ages of 15 and 24. This has been estimated to equal approximately 30,000 suicides each year, about 12.5 deaths per 100,000 Americans.

Depression has been subdivided into several forms with the two major groups being bipolar and unipolar. Patients with bipolar depression experience mood swings between major depression and periods of mild but chronic agitation (hypomania) or severe agita-

tion (mania). The latter type is also referred to as manic-depressive disorder.

The unipolar subtype is major depression with no history of mania or hypomania. It is further subdivided into **delusional,** depressive symptoms associated with psychotic symptoms; **melancholia,** classical symptoms of early morning wakening and depressed feelings that may lessen during the day, loss of appetite and weight; **atypical,** excessive sleeping or eating and being overly sensitive to rejection by another; **dysthymia**, depressed mood is sporadic or in some patients lasts for several years; and **unspecified,** depressed persons who do not fit into any of the above groups. Another type of depressive disease is **obsessive-compulsive disorder** in which affected patients perform normal activities, such as washing their hands, in an obsessive manner and cannot stop.

As stated earlier, there are no objective means to determine whether a person suffers from depression, or what type of depression is present. Diagnosis relies on interviews with the patient to obtain a thorough psychological history. Therapy is then individualized.

A number of methods for establishing a clinical diagnosis of depressive illnesses has been derived. One of the most popular is the "DSM-III-R" method published in the *Diagnostic and Statistical Manual of Mental Disorders.* Criteria are presented in Table 2.

Since depression appears to be due to an imbalance of neurotransmitters in the brain, therapy is aimed at restoring the balance.

Nondrug Treatment of Depressive Disorders

Two nondrug methods for treating depression are **electroconvulsive treatment (ECT)** and **psychotherapy.** ECT involves administering an electrical stimulus at an intensity sufficient to induce seizures. Prior to therapy, the patient is anesthetized to alleviate discomfort and anxiety, and given muscle relaxants to reduce the chance of muscle damage or bone fractures.

While some individuals consider ECT to be barbaric, others believe it is no different from pushing the reset button on a computer or VCR. ETC is especially beneficial to patients who do not respond or who react adversely to antidepressant drugs, those at a high risk of suicide, and those with cardiovascular diseases. The frail elderly are also good candidates for ECT therapy.

Table 2
Diagnostic Criteria for Establishing Major Depressive Illness

1. At least 5 of the following symptoms present during the same 2 week period representing a change from previous behavior; at least one of the symptoms is (a) or (b):
 a) depressed mood
 b) markedly diminished interest in normal activities
 c) significant weight loss or gain when not dieting, or decreased or increased appetite
 d) insomnia or hypersomnia
 e) psychomotor agitation or retardation
 f) fatigue or loss of energy
 g) feelings of worthlessness or inappropriate guilt
 h) diminished ability to think or concentrate
 i) recurrent thoughts of death or suicide

2. a) An organic (internal disease) factor that initiated or maintains the problem that cannot be determined.
 b) The disturbance is not a normal reaction.

3. At no time during the episode have there been delusions or hallucinations for as long as two weeks in the absence of prominent mood symptoms.

4. The episode is not superimposed on schizophrenia, delusional or other psychic disorders.

Reference: *Diagnostic and Statistical Manual of Mental Disorders,* 3rd Edition

While the use of ECT for treatment of depression is not as widespread as drug therapy, it is reportedly the most effective therapy for major depressive disorders. ECT treatment is clinically effective in 80 to 90 percent of patients. Patient response to drug therapy is about 70 percent, and to placebo approximately 30 percent.

Antidepressant Mechanism of Action

In spite of years of intensive research on antidepressant drugs and administration of millions of doses, their exact mechanism of action has not been elucidated. Several theories have been advanced on how antidepressants and other psychotherapeutic drugs act. Among these are the biogenic amine theory and the newer theory, receptor regulation (up or down).

The **biogenic amine** theory has been popular for the last twenty years. It holds that depression (as well as anxiety and other affective mental disorders) results from a deficiency of relative concentrations of biogenic amines in the synaptic areas between neurons in the central nervous system. Biogenic amines include the monoamines: norepinephrine, dopamine and serotonin.

This theory was advanced after it was learned that drugs which deplete or retard the activity of norepinephrine in the central nervous system (e.g., reserpine, methyldopa) can cause depression. The first group of consistently effective antidepressants increased monoamine activity (i.e., the monoamine oxidase inhibitors.) The tricyclic antidepressants and more recently released antidepressant drugs also affect monoamine activity by blocking the reuptake of neurotransmitters into their storage areas inside nerve cells. This causes more of the monoamines to be in the synaptic space between neurons which, in turn, is thought to be responsible for alleviating depression.

Advocates of the biogenic amine theory state that the basis for depression is caused by a deficiency in the synaptic concentration and activity of norepinephrine and/or serotonin. Their belief is further advanced by the fact that different patients obtain differing levels of therapeutic activity from the various antidepressants, and the difference between these drugs is their relative potency in modifying norepinephrine or serotonin concentrations in neuronal synaptic spaces.

A major flaw in this theory is the delay in onset of action of psychotherapeutic agents. While these drugs modify monoamine activity within hours after a single dose, therapeutic response takes several weeks. Another problem is that there are a number of reuptake inhibitors with no effective antidepressant activity.

The newer **receptor regulation** theory states that the psychotherapeutic action of antidepressant and antipsychotic drugs is due to their effect on the number and sensitivity of adrenergic and serotonin (5-HT) receptors on neurons in the brain. Advocates of this theory hold that the change in monoamine levels in the synaptic spaces is important, but not the primary effect of these drugs. Instead, they believe that the increased concentration of monoamines reduces the number of receptor sites on the axons of adjacent neurons.

While it is difficult to understand this theory, it has been found that antidepressants do reduce the total number and sensitivity of alpha-2 adrenergic, beta-adrenergic, and 5-HT2 receptors in the brain. It takes approximately 2 to 3 weeks for this "down" regulation to occur, which is more in line with the time period needed for full therapeutic effects to be seen. Additionally, it has been shown that while neurotransmitter levels are increased by antidepressants for a few days, they return close to normal after 2 to 3 weeks of therapy.

Antidepressant Therapy

Treatment of depression was revolutionized in the early 1950s with discovery of the monoamine oxidase inhibitors (MAOI), and with the introduction of the tricyclic antidepressants (TCAs) later in the decade. Over the next 20 years, drugs representing nearly a dozen molecular manipulations of the basic TCA chemical structure were brought to the market.

While all of these agents provided significant therapeutic results, many patients could not tolerate the side effects of drowsiness,

Table 3
Patient Information for Effexor

Effexor is used to treat depression and other conditions as determined by your doctor.

- The manufacturer of Effexor recommends that the starting doses be taken with food.

- Some people may experience dizziness, blurred vision or drowsiness from Effexor. If you do, be careful driving or performing hazardous tasks. Alcoholic beverages can increase the drowsiness effect.

- Some people may experience lightheadedness while taking Effexor. Sit or lie down at the first signs. Avoid sudden changes in posture. Be careful going up and down stairs.

- DO NOT take nonprescription cough/cold, allergy, sleep aid, or diet medications while taking Effexor without asking your doctor or pharmacist.

- It make take several weeks before the full effects of Effexor are noticed. DO NOT change the amount of Effexor taken or stop taking it without consulting your doctor.

- Some people may experience dry mouth. If you do, suck on hard candy, chew gum or use a saliva substitute.

- If you miss a dose of Effexor, take it as soon as possible. But, if it is almost time for your next dose, skip the missed dose and go back to your regular dosing schedule. DO NOT take a double dose, unless directed by your doctor.

- DO NOT keep or use outdated medication.

- Keep Effexor at room temperature, in its original, labeled container and out of the reach of children.

- In case of accidental ingestion or overdose, call your doctor or poison control center immediately.

- WOMEN: While taking Effexor, you should tell your doctor if you plan to become pregnant, are pregnant, or if you are breast-feeding an infant.

- Every medication is capable of producing side effects. Most patients experience few or no problems while taking Effexor. However, be sure to tell your doctor if the following occur: nausea, diarrhea, nervousness, irregular heartbeat or pulse, headache, difficulty getting to sleep or urinating, unusual tiredness, hallucinations, skin rash or hives, or any other unusual, bothersome effects.

Adapted from the Pharmex PALs (patient advisory leaflets).
For more information, call 1-800-233-0585.

constipation, orthostatic hypotension, dry mouth, and blurred vision. This is because TCAs are not selective in their receptor blockade. They also block cholinergic, histamine, alpha-adrenergic, serotonin-1 and serotonin-2 receptors.

TCAs also exert a quinidine-like action on the heart and slow the conduction of electrical impulses through the myocardium. In most patients this is of little consequence. In others, especially in overdose, it can result in fatal arrhythmias.

During the 1980's, several "second generation" antidepressants (i.e., Asendin, Desyrel, Ludiomil, Wellbutrin) were released. These drugs, for the most part, caused fewer anticholinergic side effects than TCAs. However, in some patients, increased extra-pyramidal symptoms (Parkinsonism) or seizure activity were a problem.

Over the past few years, the serotonin-specific reuptake inhibitors (SSRI: Paxil, Prozac, Zoloft) have been approved for use in treating depression. As the name of the group implies, they exert specific action on the reuptake of serotonin with no measurable effect on norepinephrine. They lack activity on cholinergic, adrenergic or histamine receptors so they cause far fewer side effects or less cardiac toxicity than previously available antidepressants.

The most recent addition to the family of antidepressants is venlafaxine (Effexor). It reportedly blocks the uptake of serotonin and norepinephrine, and to a lesser extent, dopamine. It has neither cholinergic, histamine or adrenergic blockade properties.

There are many who believe that all commercially available antidepressants are equally effective and that selection of the "best" drug must be individualized and dependent on the patient's response to previous therapy and the avoidance of side effects. If this is true, the newer drugs have a clear advantage over previously available antidepressants. The difference between the SSRI and venlafaxine would be whether the blockade of norepinephrine is beneficial for that particular patient. Generally, the only way to determine this is to try the various drugs and see how the patient reacts.

Venlafaxine ("1S") – Trade Name: Effexor

Venlafaxine, the newest entry to the group of antidepressant drugs, is the first of what its manufacturer calls a class of serotonin-norepinephrine reuptake inhibitors. Claims are made that it has a more rapid onset of action than previously available antidepressants. Venlafaxine is as effective as other available antidepressants and causes fewer side effects than TCAs and second generation antidepressants.

Because it increases extracellular levels of norepinephrine, venlafaxine has the potential for increasing blood pressure and heart rate. Therefore it should be used with caution, if at all, in patients with hypertension or other cardiovascular disease.

As with the other antidepressants, venlafaxine is contraindicated concurrently with or within two weeks of monoamine oxidase inhibitors. No direct interaction has been seen, but the contraindication is based on the occurrence of serious, even fatal, reactions in patients receiving other antidepressants concurrently with monoamine oxidase inhibitor therapy.

Side effects reported at the 5 percent or higher level, and not seen at an equivalent level in placebo-treated patients in clinical trials, are sweating, nausea, constipation, anorexia, vomiting, somnolence, dry mouth, dizziness, nervousness, anxiety, tremor and blurred vision.

In clinical trials with males, sexual dysfunction with abnormal ejaculation/orgasm or impotence were observed at 6 percent and 12 percent respectively with Effexor. In comparison, during their clinical trials, similar male genital disorders were seen in 15.5 percent of patients on Zoloft, 12.9 percent of those on Paxil and 1.9 percent of Prozac treated patients.

Effexor is marketed as 25, 37.5, 50, 75 and 100mg tablets. The recommended initial dose is 75mg daily either as 25mg tid or 37.5mg bid. This can be titrated upward to 225mg daily based on patient response.

Its manufacturer states that the starting dose should be taken with food. Unfortunately, ex-

actly what the term "starting dose" means is not explained, the reason is not given, and the topic is not addressed in the patient information section of the product's package insert. The manufacturer does state that food has no significant effect on the absorption of venlafaxine.

Additional information useful in counseling patients on the proper use of Effexor is listed in Table 3.

A professional development program made possible by an educational grant from

SEARLE

CONTINUING EDUCATION QUIZ

Patient Counseling: New Drugs of 1994-95, Part 1: Antidepressant Agents

1. Which of the following is a type of bipolar depression?
 a. Obsessive-compulsive
 b. Manic-depressive
 c. Delusional
 d. Melancholia

2. The biogenic amine theory for mental disorders was advanced when it was discovered that depression is caused by drugs that:
 a. deplete or retard serotonin activity.
 b. deplete or retard norepinephrine activity.
 c. increase or enhance serotonin activity.
 d. increase or enhance norepinephrine activity.

3. A major flaw in the biogenic amine theory of mental disorders is:
 a. the rapid onset of psychotherapeutic drugs.
 b. norepinephrine is not involved in the thought process.
 c. the delay in onset of psychotherapeutic drugs.
 d. serotonin is not involved in the thought process.

4. All of the following statements are true EXCEPT:
 a. depression reportedly occurs more often in women than men.
 b. as much as 10 percent of the adult population experiences clinical depression at some time.
 c. it is believed that the thought process is a series of chemical reactions which determine how individuals perceive reality.
 d. there are excellent instruments for measuring the occurrence and extent of depression.

5. Venlafaxine reportedly has the LEAST activity on which of the following neurotransmitters?
 a. Acetylcholine
 b. Dopamine
 c. Norepinephrine
 d. Serotonin

6. The group of patients for whom venlafaxine has the greatest potential for adverse effects are those with:
 a. cardiovascular disease.
 b. diabetes.
 c. glaucoma.
 d. thyroid disease.

7. Patients receiving a prescription for Effexor should be advised not to self-medicate with OTC:
a. antacids.
b. bulk laxatives.
c. pain relievers.
d. sleep aids.

8. All of the following are classic signs of depression EXCEPT:
a. false beliefs.
b. constant agitation.
c. feelings of guilt.
d. low self-esteem.

9. The most effective therapy for major depressive disorders is:
a. psychotherapy and guidance training.
b. monoamine oxidase inhibitors.
c. electroconvulsive treatments.
d. serotonin-specific reuptake inhibitors.

10. All of the following are members of the SSRI group of antidepressants EXCEPT:
a. Zoloft.
b. Prozac.
c. Paxil.
d. Effexor.

Cut out or Reproduce and Mail

CONTINUING PHARMACEUTICAL EDUCATION (CPE)

Patient Counseling: New Drugs of 1994-95, Part 1: Antidepressant Agents

- Attach a mailing label from *The Carolina Journal of Pharmacy* or print your name and address and mail with payment of $7.00 to CE Test, NCPhA, P.O. Box 151, Chapel Hill, NC 27514–0151
- Completed answer sheets may be returned on a monthly or less frequent basis for grading. **Quizzes not accompanied by payment will not be processed and will be discarded.**
- **This is a member service. Non-member tests will not be graded nor CPE credit hours given.**
- NCPhA will maintain a copy of your completed CPE tests and upon successful completion of each program, will issue a certificate for one (1) hour of North Carolina Board of Pharmacy approved CPE credit.
- If more than two (2) questions are answered incorrectly, the test is failed. You will be given one (1) opportunity to submit a second answer sheet.

Please circle correct answer

1. a b c d	4. a b c d	7. a b c d
2. a b c d	5. a b c d	8. a b c d
3. a b c d	6. a b c d	9. a b c d
		10. a b c d

Evaluation of material: Excellent Good Fair Poor

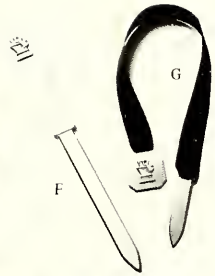
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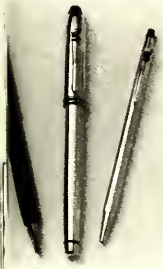


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STATEMENT OF OWNERSHIP, MANAGEMENT AND CIRCULATION

Required by 39 U.S.C. 3685)

1A. Title of Publication	1B. PUBLICATION NO.	2. Date of Filing
CAROLINA JOURNAL OF PHARMACY	0 9 1 - 2 8 0	OCTOBER 1, 19
3. Frequency of Issue	3A. No. of Issues Published Annually	3B. Annual Subscription Price
BIMONTHLY	6	$25.00

4. Complete Mailing Address of Known Office of Publication *(Street, City, County, State and ZIP+4 Code) (Not printers)*

109 CHURCH STREET, CHAPEL HILL NC 27516-2502

5. Complete Mailing Address of the Headquarters of General Business Offices of the Publisher *(Not printer)*

NORTH CAROLINA PHARMACEUTICAL ASSOCIATION
109 CHURCH STREET, CHAPEL HILL NC 27516-2502

6. Full Names and Complete Mailing Address of Publisher, Editor, and Managing Editor *(This item MUST NOT be blank)*

Publisher *(Name and Complete Mailing Address)*

NORTH CAROLINA PHARMACEUTICAL ASSOCIATION
A.H. MEBANE III EDITOR 109 CHURCH STREET, CHAPEL HILL NC 27516-2502

Editor *(Name and Complete Mailing Address)*

A. H. MEBANE III
SAME ADDRESS

Managing Editor *(Name and Complete Mailing Address)*

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7. Owner *(If owned by a corporation, its name and address must be stated and also immediately thereunder the names and addresses of stockholders owning or holding 1 percent or more of total amount of stock. If not owned by a corporation, the names and addresses of the individual owners must be given. If owned by a partnership or other unincorporated firm, its name and address, as well as that of each individual must be given. If the publication is published by a nonprofit organization, its name and address must be stated.) (Item must be completed.)*

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8. Known Bondholders, Mortgagees, and Other Security Holders Owning or Holding 1 Percent or More of Total Amount of Bonds, Mortgages or Other Securities *(If there are none, so state)*

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The purpose, function, and nonprofit status of this organization and the exempt status for Federal income tax purposes *(Check one)*

[X] (1) Has Not Changed During Preceding 12 Months
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10. Extent and Nature of Circulation *(See instructions on reverse side)*	Average No. Copies Each Issue During Preceding 12 Months	Actual No. Copies of Single Iss Published Nearest to Filing Da
A. Total No. Copies *(Net Press Run)*	2800	2800
B. Paid and/or Requested Circulation 1. Sales through dealers and carriers, street vendors and counter sales		
2. Mail Subscription *(Paid and/or requested)*	2400	2306
C. Total Paid and/or Requested Circulation *(Sum of 10B1 and 10B2)*	2400	2306
D. Free Distribution by Mail, Carrier or Other Means Samples, Complimentary, and Other Free Copies	150	150
E. Total Distribution *(Sum of C and D)*	2550	2456
F. Copies Not Distributed 1. Office use, left over, unaccounted, spoiled after printing	245	244
2. Return from News Agents		
G. TOTAL *(Sum of E, F1 and 2—should equal net press run shown in A)*	2800	2800

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Signature and Title of Editor, Publisher, Business Manager, or Owner

PUBLISHER & EDITOR

PS Form 3526, Feb. 1989 *(See instructions on reverse)*

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Classified advertising rates are 25 cents a word for members with a minimum of $5.00 per insertion. For nonmembers, classified ads are 50 cents a word with a minimum charge of $10.00 per insertion. Ads are accepted for a single issue or specific time period only. The closing date for ad orders is the first of the month preceding the issue in which you are requesting insertion. Payment for ad orders will be billed. Names and addresses will be published unless an ad number for a blind ad is requested. In replying to blind ads, send to Ad (), c/o NCPhA, P.O. Box 151, Chapel Hill, NC 27514. Telephone 800-852-7343 or 919-967-2237.

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TECHNICIAN CERTIFICATION DATES ANNOUNCED

The Pharmacy Technician Board (PTCB) has announced the dates for the 1996 national pharmacy technician certification exams. The exam will be administered three times in 1996 in Asheville, Charlotte, and Durham.The exam dates and deadlines for registering/applying for the exams are as follows:

Exam Date	Application Deadline
March 23	January 26
July 27	May 31
November 2	September 6

Information about the exam and official application materials may be obtained by contacting NCPhA at 1-800-852-7343. The examination fee will remain at $95 for 1996. Successful candidates will be certified for a 2-year time period and are allowed to use the Certified Pharmacy Technician designation, "CPhT." Technicians may contact NCPhA to request study guides and other helpful information.



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